



The signs  
of a healthier Vermont



*Certificate of Coverage*

***BlueCare***

[www.bcbsvt.com](http://www.bcbsvt.com)



**The Vermont  
Health Plan**

An independent licensee of the Blue Cross and Blue Shield Association.

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## This is your Certificate of Coverage, a part of your Contract.

Your Contract governs your Benefits. These are the documents in your Contract:

- This **Certificate of Coverage**, which describes your Benefits in detail and explains requirements, limitations and exclusions for coverage.
- Your **Outline of Coverage**, which shows what you must pay Providers and which Services require Prior Approval.
- Any **riders** or **endorsements** listed on your **Outline of Coverage**, which describe additional coverage or changes to your Contract.
- Your **ID card**.
- Your **Group Enrollment Form** (your application) and any supplemental applications that you submitted and we approved.

We sometimes replace just one part of your Contract. This Certificate is current until we update it. 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, "How We Determine Your Benefits." That information applies to all Services. Pay special attention to the "Prior Approval Program" on page 5.
- Find the Service you need in Chapter Two, "Covered Services." You may use the Index or Table of Contents to find it. Read the section thoroughly.
- Check "General Exclusions" to be sure the Service you need is not on this list.
- To find out what you must pay for a Service or supply and whether you need Prior Approval, check your Outline of Coverage.
- Please remember that to know the full terms of your coverage, you should read your entire Contract.
- Some terms in your Certificate have special meanings. We capitalize these terms in the text. We define them in the last chapter of this booklet. Read "Definitions" to fully understand your coverage. The terms "we," "us," "our," "include(s)," "including," "you" and "your" are also defined, but not capitalized in the text.
- If you need materials translated into a different language or if you need translation services to work with our customer service department, call the customer service number on the back of your ID card.

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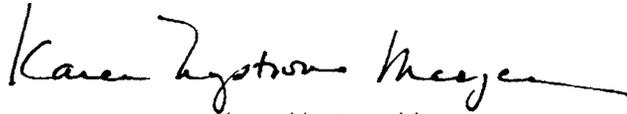


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# BlueCare Certificate of Coverage

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 is discontinued, terminated or voided as allowed by its provisions. (See Chapters Seven and Eight.)



Karen Nystrom Meyer  
Chair of the Board



Don C. George  
President and CEO



Christopher Gannon  
General Counsel & Secretary



**CHAPTER ONE**

# Guidelines for Coverage

This Certificate describes Benefits for the BlueCare health plan. It is a health maintenance organization (HMO) plan issued by The Vermont Health Plan, LLC. An HMO plan provides Benefits only when you follow managed care guidelines. If you do not follow these guidelines, you may not receive Benefits, except as otherwise provided by law.

Chapter One explains how to get Benefits through your health plan. Your Outline of Coverage shows what you must pay. Read this entire chapter carefully, as you must 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 “Definitions” to understand your coverage. The terms “we,” “us,” “our,” “include(s),” “including,” “you” and “your” are also defined, but not capitalized in the text.
- We only pay Benefits for Services we define as Covered by this Contract. You must also use Providers (see our definition). For most Services, you must use Providers in our Network.
- 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).

- We may interpret and apply the terms of this Contract. We may determine if you have coverage for care. We may also decide how much coverage you have. This applies even when a Provider has prescribed or recommended a Service.
- 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.

## Primary Care Physicians Services

When you join this plan, you must select a Primary Care Physician from our Network of Primary Care Physicians. You may select a different Primary Care Physician for each member of your family. You may select a pediatrician for a child. You must receive Services from your Primary Care Physician or another Network Provider to receive Benefits.

Your coverage does not require you to get referrals from your Primary Care Physician. This includes when you use other Providers. You must get Prior Approval for any Services you receive from Providers outside our Network. You must get prior approval for the services listed in the next section, including care outside of our Network. Network Providers will take care of Prior Approval for you.

## Prior Approval Program

We require Prior Approval for certain Services and drugs. They appear on the list later in this section. Network Providers get Prior Approval for you. If you fail to get Prior Approval before receiving care from a Non-network Provider, we will deny Benefits. You may appeal our denial using the process in Chapter Four. If you can show that the Services you received were Medically Necessary, we will provide Benefits. If you use a Network Provider and the Provider fails to get Prior Approval for Services that require it, the Provider may not bill you.

We do not require Prior Approval for Emergency Services. See our definition of Emergency Services on page 39. We do request that you or your Provider contact us as soon as possible after the emergency.

Our Prior Approval list can change. We inform you of changes using newsletters and other mailings. To get the most up-to-date list, visit our website at **[www.bcbsvt.com](http://www.bcbsvt.com)** or call customer service at the number on the back of your ID card.

As of the printing of this Certificate, these Services required Prior Approval:

- Air or water Ambulance transport and non-emergency ground Ambulance;
- Anesthesia for colonoscopy or endoscopy
- Treatment of autism (when it's Covered, effective July 1, 2012);
- Capsule endoscopy;
- Chiropractic care after 12 visits in a Plan Year;
- Chondrocyte Transplants;
- Outpatient, 72-hour continuous glucose monitoring;
- Continuous Passive Motion (CPM) Equipment;
- Oral Surgery, dental trauma and orthognathic Surgery and oral lesion excision and biopsy;
- Durable Medical Equipment (DME) with a purchase price over \$500;
- Endocrinology
- Genetic Testing;
- Hip Resurfacing
- Home Infusion Therapy;
- Hospice Care;
- Hyperbaric Oxygen Therapy;
- Medical Nutrition for Inherited Metabolic Disease (medical supplies and pumps, enteral formulae and parenteral nutrition);
- Mental Health and Substance Abuse Treatment;
- New procedures still considered Investigational or experimental;
- Orthotics;
- Osteochondral Autograft Transfer System (OATS)/Mosaicplasty;
- Out-of-Network Services
- Out-of-State Inpatient care;
- Plastic and Cosmetic Procedures except breast reconstruction for patients with a diagnosis of breast cancer;
- Polysomnography (sleep studies) and Multiple Sleep Lateral Testing (MSLT);
- Prescription Drugs (separate lists apply, please see Rx Center at [www.bcbsvt.com](http://www.bcbsvt.com));
- Private Duty Nursing;
- Prosthetics;
- Radiology Services (examples include CT, MRI, MRA, MRS, PET and nuclear cardiology);
- Rehabilitation (cardiac/pulmonary/Inpatient rehabilitation Facility);

- Certain surgical procedures including bariatric (obesity) Surgery, collis gastroplasty, gastric electrical stimulation, percutaneous vertebroplasty, varicose veins/venous insufficiency, vertebral augmentation, temporomandibular joint manipulation/ Surgery and anesthesia and tumor embolization;
- Transcutaneous Electrical Nerve Stimulation (TENS) Units/Neuromuscular Stimulators
- Transplants (except kidney and corneal);
- UPPP/Somnoplasty; and
- Wound care management.

### How to Request Prior Approval

To get Prior Approval, you or your Provider must send a letter with supporting documentation to BCBSVT. Our forms can help. They are on our website at [www.bcbsvt.com](http://www.bcbsvt.com). You may also get them by calling our customer service team.

Network Providers take care of Prior Approval for you. Any Provider may help you fill out the form and give you other information you need to submit your request. The medical staff at BCBSVT will review the form and respond in writing to you and your doctor.

### Prior Approval for Mental Health Services and Substance Abuse Treatment Services

You must get Prior Approval from us before you receive Inpatient or Outpatient treatment. You do not need Prior Approval for Emergency Services. We do request that you or your Provider contact us as soon as possible after the emergency. See definition of Emergency Services on page 39. Call the number on the back of your ID card to get approval from our Mental Health and Substance Abuse Network. See other requirements for Mental Health and Substance Abuse Care on page 17 and page 19

### Case Management Program

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

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

## Choosing a Provider

For some types of Services, you must choose a Network Provider. We choose Network Providers who we feel 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.

## Network Providers

The Vermont Health Plan has a network of Primary Care Physicians and specialists. This network is separate from our Participating Provider network. Most, though not all, Network Providers are also Participating Providers.

To access list, of Network providers, please visit our website at [www.bcbsvt.com](http://www.bcbsvt.com). You may then use the Find a Doctor application. You may also call customer service at the number on the back of your ID card. We will send you a paper Provider directory if you wish.

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

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

Network primary care physicians include family practitioners, pediatricians or internists. You should be able to find a Network primary care physician within a 30-minute drive from your home. You should find routine, office-based Mental Health and or Substance Abuse care from a Network Provider within a 30-minute drive as well. You'll find Participating or Network specialists for most types of care within a 60-minute drive from your home. They include optometry, laboratory, imaging and Inpatient medical rehabilitation Providers. This also includes intensive Outpatient, partial hospital, residential or Inpatient Mental Health and Substance Abuse Services. You can find Network Providers for less common specialty care within a 90-minute drive. This includes kidney transplantation, major trauma treatment, neonatal intensive care and tertiary-level cardiac Services. This also includes cardiac catheterization and cardiac Surgery.

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

We have special Networks for some types of Providers. For example, we have a Network of mental health professionals. We do not Cover your care if you use one of the following Providers that is not a Network Provider:

- certified nurse midwives or professional midwives,;
- Chiropractors;
- medical equipment and supplies Providers;
- nutritional counseling Providers (including registered dietitians, licensed nutritionists, certified diabetic educators, medical doctors (MDs), doctors of osteopathy (DOs), naturopathic physicians and nurse practitioners);
- oral surgeons;
- Pharmacies (if your coverage includes a Prescription Drug Rider);
- Primary Care Physicians;
- routine vision care Providers (if your coverage includes routine vision Benefits); and
- Substance Abuse treatment Providers.

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

## After-hours and Emergency Care Emergency Services

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

Emergencies might include:

- broken bones
- heart attack
- choking

You will receive care right away in an emergency.

If you have an emergency at home or away, call 9-1-1 or go to the nearest doctor or emergency room. You don't need any approvals 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 Services from a Non-network Provider, we will Cover your Emergency Care as if you had been treated by a Network Provider. You must pay any cost sharing amounts required under your Contract as if you received those Services from a Network Provider. These may include Deductibles, Co-insurance or Co-payments. If a Non-network Provider requests any payment from you other than your cost sharing amounts, please contact 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 doctor's office when you need care—even after office hours. He or she (or a covering doctor) can help you 24 hours a day, seven days a week. Do you have questions about care after hours? Ask now, before you have an urgent problem. Then keep your doctor's phone number handy in case of late-night illnesses or injuries. For more on after-hours care, see "Emergency Services."

### Out-of-Area Services

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain health care Services outside of our service area, the claims for these Services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside our service area, you will obtain care from health care Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue").

In some instances, you may obtain care from Non-network or Non-participating health care Providers. Our payment practices in both instances are described below. We Cover only limited health care Services received outside of our service area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency care, urgent care and care outlined under "Out-of-Area Coverage for Students" above that is obtained outside the geographic area we serve. Any other Services will not be Covered when processed through any Inter-Plan Programs arrangements. These "Other Services" must be provided or authorized by your Primary Care Physician ("PCP").

### BlueCard® Program

Under the BlueCard® Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling [our/Licensee Name] contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its Participating health care Providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a health care Provider participating with a Host Blue, where available. The Participating health care Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Co-payment amount, as stated in your Outline of Coverage.

**Emergency Care Services:** If you experience a Medical Emergency while traveling outside our service area, go to the nearest Emergency or Urgent Care facility. Whenever you access Covered health care Services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar co-payment, is calculated based on the lower of:

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care Services according to applicable law.

## Out-of-Area Coverage for Students

This section describes Benefits for students getting medical Services outside the state of Vermont.

It does not apply to out-of-area Benefits for Emergency Services. We do not describe Mental Health and Substance Abuse Treatment or prescription drugs in this section. We explain those out-of-area benefits in other parts of your Contract. This section also does not apply to Services rendered by Providers in The Vermont Health Plan's Network, even if they are out of state. (We may contract directly with Providers in neighboring states, for example.)

You must get Prior Approval from us for the Covered Services below. Please make sure the Provider you use is Participating with the local Blue Cross and Blue Shield Plan. (See Out-of-area Services below.)

You must get Prior Approval from us for the Covered Services listed below. Please make every effort to ensure the Provider you use is Participating with the local Blue Cross and Blue Shield Plan.

### Covered Services:

- Emergency Services or Urgent Services, including Urgent Services for Acute, minor illnesses;
- ongoing care for which it is medically necessary for a local specialist to be familiar with the individual member's condition (these conditions require visits and medication adjustments during the academic year and Services cannot safely and effectively be provided during defined school breaks);<sup>1</sup>
- Physical Therapy, Occupational Therapy and Speech Therapy Services for injuries sustained at school or which must extend beyond school breaks; and
- allergy injections.

<sup>1</sup> These are conditions that are potentially life threatening or pose a threat to long-term health if not evaluated and treated on a regular basis throughout the year. Examples include but are not limited to unstable asthma, diabetes and juvenile rheumatoid arthritis.

### Non-covered Services:

- elective procedures and surgeries that can safely, effectively and reasonably be performed by returning to Vermont;
- Preventive Services, routine office visits and associated Diagnostic Services;
- routine immunizations; and
- chiropractic care.

## How We Determine Your Benefits

When we receive your claim, we determine:

- If this Contract Covers the medical Services you received; and
- your Benefit amount. In general, we pay our Allowed Price. See "Allowed Price" later in this section. We may subtract any:
  - Benefits paid by Medicare;
  - Deductibles (explained below);
  - Co-payments (explained below);
  - Co-insurance (explained below);
  - any amounts paid or due from other insurance carriers through coordination of Benefits. See chapter Six for more information.

Your Outline of Coverage shows your Deductible, Co-insurance and Co-payment amounts. We may limit Benefits to any Plan year shown on your Outline of Coverage. We may also limit lifetime maximums.

## Payment Terms

### Allowed Price

The Allowed Price is the amount we consider reasonable for a Covered Service or supply.

#### Note:

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

### Deductible

Your Outline of Coverage lists your Deductible amounts. You must meet your Deductible each Plan year before we make payment. If not we may not make payment on certain Services. We apply your Deductible to your out-of-pocket limit for each Plan year. Your

Deductible amount may change during the year. It can change if your Group changes your plan on the Group anniversary date.

Some plans limit the amount of Deductible a family must pay in a Plan year. Your Outline of Coverage lists your plan's family Deductible, if applicable. When your family meets the family Deductible, all family members have met their individual Deductibles.

### **Co-payment**

You must pay Co-payments to Providers for specific Services. Your Outline of Coverage shows these services. Your Provider may require payment at the time of the Service. We do not apply Co-payments toward your out-of-pocket limit.

You may have different Co-payments depending on the Provider you see. For example, you may pay a lower Co-payment when you see your Primary Care Physician or an OB-GYN than when you use other Providers. Check your Outline of Coverage for details.

### **Co-insurance**

You must pay Co-insurance to Providers for specific Services. Your Outline of Coverage shows these services. We calculate the Co-insurance amount. We do so by multiplying the Co-insurance percentage by the Allowed Price after you meet your Deductible. We apply your Co-insurance toward your out-of-pocket limit for each Plan year.

### **Out-of-Pocket Limit**

Your Outline of Coverage lists your out-of-pocket limit, if you have one. Deductibles and Co-insurance make up the out-of-pocket limit. After you meet your out-of-pocket limit, you pay no Co-insurance for the rest of that Plan year. You may still be responsible for Co-payments, when they apply.

Your Outline of Coverage lists your plan's family out-of-pocket limit, if applicable. When your family meets the family out-of-pocket limit, all family members have met their individual out-of-pocket limits.

### **Plan year and Lifetime Benefit Maximums**

Your Outline of Coverage lists your Plan year. Your Outline of Coverage will also list your lifetime Benefit maximums. The lifetime maximum is the total amount we will provide for each enrolled individual, even if your employer offers more than one health plan Benefit option. The Benefit limits in your Outline of Coverage apply across all such plan options. The only exception is if your employer's summary plan description states otherwise. After we have provided maximum Benefits, you must pay all charges. Please contact your employer if you have questions about the summary plan description.

**CHAPTER TWO**

# Covered Services

Chapter Two describes Covered Services. This chapter also covers guidelines and policy rules for obtaining Benefits. Please refer to your Outline of Coverage for Benefit maximums. You can also refer to your Outline of Coverage for payment terms. Payment terms include Co-payments and Deductibles.

For information about Mental Health Providers' Services, please read the "Mental Health Care" section. Read each section of this certificate carefully. Limitations may apply.

## Office Visits

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

- the examination, diagnosis and treatment of an injury or illness;
- Preventive care, including routine physical examinations, immunizations and well-child care;
- injections;
- Diagnostic Services such as X-rays,
- Emergency Services (see definition on page 39);
- Surgery; and
- therapy Services.

## Nutritional Counseling

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

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

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- registered dietitian (R.D.);
- nutritionist licensed in Vermont;
- certified diabetic educator (C.D.E.);
- naturopathic physician (N.D.); or
- nurse practitioner.

## Notes:

- We Cover newborns. Under this Contract, we Cover newborns for up to 31 days after birth. (Refer to Chapter Seven for how to continue coverage for your newborn past this period.)
- We describe office visit Benefits for Mental Health Services and Substance Abuse treatment Services elsewhere in this Chapter. We also describe chiropractic Services in this Chapter. Please see those sections for Benefits.
- You must get Prior Approval for certain Services in order to receive Benefits. See page 5 for a description of the Prior Approval program. See our website for the newest list of Services that require Prior Approval. You may also call customer service.

Please remember that General Exclusions in Chapter Three also apply.

## Exclusions

We do not Cover:

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

General Exclusions in Chapter Three also apply.

## Ambulance

We provide Benefits for Ambulance Services as long as your condition meets our definition of an Emergency Medical Condition.

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 Services on your Outline of Coverage. This includes Ambulance Services for non-emergency transport. We will not Cover your care without it. You do not need Prior Approval if your condition meets our definition of an Emergency Medical Condition.

- To receive Benefits, your Services must meet guidelines in Chapter One.
- We Cover transportation only to the closest Facility that can provide Services appropriate for the treatment of your condition.
- We do not Cover Ambulance Service when the patient can travel by private car. This rule applies whether or not a private car is available.

## Chiropractic Services

We Cover care by Chiropractors who are:

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

We Cover Acute and Supportive chiropractic care, including:

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

Requirements and conditions that apply to coverage for Services by Providers apply to this coverage. However, this does not include Chiropractors. You can use 12 chiropractic visits in one Plan year. After the 12th visit, you must get Prior Approval from us for any other visits. Your Chiropractor must submit a treatment plan and written request for Prior Approval. He or She must submit to us. He or She may do so by mail.

The address for Prior Approval is:

BCBSVT Medical Services  
P.O. Box 186, Montpelier, VT 05601-0186

Your Chiropractor may also fax to (802) 371-3491. See page 9 for more information about the Prior Approval program.

### Exclusions

We provide no chiropractic Benefits for:

- Wellness (Maintenance) chiropractic care (see Definitions);
- treatment after the 12th visit if you don't get Prior Approval;
- Services by a Provider who is not in our Network;
- Services, including modalities, that do not require the constant attendance of a Chiropractor;

- treatment of any "visceral condition," that is a dysfunction of the abdominal or thoracic organs, or other condition that is not neuromusculoskeletal in nature;
- acupuncture;
- massage therapy;
- care provided but not documented with clear, legible notes indicating patient's symptoms, physical findings, Physician'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 postnatal care;
- Custodial Care (see Definitions), as noted in General Exclusions;
- Surgery; or
- any other procedure not listed as a Covered chiropractic Service.

Please remember that General Exclusions in Chapter Three also apply.

## Dental Services

You must get Prior Approval from us for dental Services. In 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 is started within six months of the accident<sup>2</sup>.
- 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.

<sup>2</sup> A sound, natural tooth is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal conditions, or other conditions; and is not in need of treatment provided for any reason other than accidental injury. A tooth previously restored with a crown, inlay, onlay or porcelain restoration, or treated by endodontics, is not a sound natural tooth.

## Exclusions

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

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

General Exclusions in Chapter Three also apply.

## Diabetes Services

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

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- registered dietitian (R.D.);
- naturopathic Physician (N.P.)
- nutritionist licensed in Vermont;
- certified diabetic educator (C.D.E.); or
- nurse practitioner.

## Diagnostic Services

You must get Prior Approval for special radiology procedures (including CT, MRI, MRA, MRS and PET scans) and polysomnography (sleep studies) or your care will not be Covered.

We Cover the following Diagnostic Services (tests to help find or treat a condition):

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

## Emergency Room Care

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

### Requirements

We provide Benefits only if you require Emergency Services as defined in this Certificate on page 39.

## 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 Medically Necessary procedures in the home; or
- performs Physical, Occupational or Speech Therapy.

### We also Cover:

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

For more information about therapy Services, see page 19.

## Private Duty Nursing

You must get Prior Approval for private duty nursing. We Cover skilled nursing Services by a private-duty nurse outside of a hospital, subject to these limitations:

- We limit Benefits for private duty nursing to \$2,000 per member, per year.
- We provide Benefits only if you receive Services from a registered or licensed practical nurse.

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

## Requirements

We Cover home care Services only when your Physician:

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

We do not Cover home care Services if the member or a lay care giver with the appropriate training can perform them.

Also, we provide Benefits only if the patient, or a legally responsible individual, consents in writing to the home care treatment plan.

## Limitations

You must get Prior Approval for home infusion therapy. We Cover home infusion therapy only if:

- your Physician prescribes a home infusion therapy regimen;
- you use Services from a Network home infusion therapy Provider; and
- you get Prior Approval.

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

## Exclusions

We provide no home care Benefits for:

- homemaker Services;
- drugs or medications except as noted above (although drugs and medications are not Covered under your home care Benefits, we may Cover them under your Prescription Drug Benefits. See your prescription drug rider for details.

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

General Exclusions in Chapter Three also apply.

## Hospice Care

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

- up to two skilled nursing visits per day;
- up to 100 hours per month of home health aide Services for personal care Services only;
- up to 100 hours per month of homemaker Services for house cleaning, cooking, etc;
- up to five days or 120 hours of continuous care Services in your home;
- up to 72 hours per month of Respite Care Services;
- up to six social service visits before the patient's death and up to two bereavement visits following the patient's death (for counseling and emotional support, assessment of social and emotional factors related to the patient's condition, assistance in resolving problems, assessment of financial resources, and use of available community resources); and
- other Medically Necessary Services.

## Requirements

We only provide Benefits if:

- a Physician certifies that the illness has a prognosis of six months life expectancy or less;
- the patient and the Physician consent to the Hospice care plan; and
- a primary caregiver (family member or friend) will be in the home.

## Hospital Care

### Note on Mental Health and Substance Abuse Treatment Services:

The description of Services below does not apply to Inpatient or Outpatient Mental Health and Substance Abuse treatment. The requirements for Mental Health Benefits appear on page 17. Requirements for Substance Abuse treatment Benefits appear on page 19.

## Inpatient Hospital Services

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

- room and board;
- “ancillary” Services, such as tests done in the hospital; and
- supplies, including drugs given to you by the hospital or Skilled Nursing Facility during a Covered stay.

We Cover either the day of admission or the day of discharge, but not both. Certain Inpatient Services require Prior Approval. Please see your Outline of Coverage for a list of these Services.

## Inpatient Medical Services

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

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

### Notes on Surgery:

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

We limit Surgery Benefits as follows:

- We Cover only one attempt at reversal of sterilization.
- We make global payments for some Surgeries and other procedures. This means that our Allowed Price for the Surgery includes payment for all office visits and other care that is related to the Surgery.
- Subject to Medical Necessity, we may limit the number of visits we Cover by one Provider in a given day.
- If you have several Surgeries at the same time, we may not pay a full allowance for each one. If you have questions about the way we determine our Allowed Price for Surgery, please call customer service at the number on the back of your ID card.

- We Cover Services of a Network certified nurse midwife or a licensed Professional midwife or a Physician for home delivery of a baby.
- We exclude many Cosmetic procedures (see General Exclusions in Chapter Three).

## Maternity

Your hospital Benefits Cover your Inpatient maternity stay. (See “Inpatient Hospital Services” above for a description of your hospital Benefits.) We also Cover the following care by a Physician or other Professional during a woman’s pregnancy:

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

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

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

We Cover newborns under this Contract for up to 31 days after birth. (See Chapter Six for information on how to continue coverage for your newborn past this period.)

## Better Beginnings® Maternity Wellness Program

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

- breastfeeding/back to work
- twins/multiples
- English as second language

Other options are available. Call customer service at the number on the back of your ID card or visit [www.bcbsvt.com](http://www.bcbsvt.com) for the available options. To join the program, call customer service as soon as possible during your pregnancy. To get any Benefits from Better Beginnings, you must actively participate. You get the most out of the Better Beginnings program when you contact us in the first three months of your pregnancy

**Notes:**

- We Cover Professional Services of a Network certified nurse midwife or a licensed Professional midwife or Physician for home delivery of a baby.
- We may provide Benefits through the Better Beginnings program for Services that we do not generally Cover, such as electric breast pump purchase, lactation consultant Services or homemaker Services. (These Services are described in the packet you receive when you join Better Beginnings.) The fact that we provide special Benefits in one instance does not obligate us to do so again.

**Outpatient Hospital Care**

You must get Prior Approval for certain radiology procedures (including CT, MRI, MRA, MRS and PET scans) and polysomnography (sleep studies). See page 14.

We Cover Services such as chemotherapy, Outpatient Surgery, diagnostic testing (like X-rays), or other Outpatient care in a General Hospital or ambulatory surgical center including:

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

For more information about therapy Services, see page 19.

**Outpatient Medical Services**

We Cover care you receive from a Physician or Professional when you are not an Inpatient. These visits include:

- Surgery (see notes on page 15);
- Services of an assistant surgeon when necessary;
- anesthesia Services for Covered procedures.

**Limitations**

We Cover only up to eight hours of neuropsychological testing per Plan year.

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

**Note on Mental Health and Substance Abuse Treatment Services**

The description of Services above does not apply to Inpatient or Outpatient Mental Health and Substance Abuse treatment. The requirements for mental health Benefits appear on page 17. Requirements for Substance Abuse treatment Benefits appear on page 19.

**Medical Equipment and Supplies****Durable Medical Equipment (DME)**

You must get Prior Approval for medical equipment and supplies with a purchase price over the dollar amount on your Outline of Coverage. This includes continuous passive motion (CPM) equipment, TENS units or Durable Medical Equipment. We Cover the rental or purchase of Durable Medical Equipment you purchase from a Network:

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

We have the right to determine whether rental or purchase is appropriate. The total rental Benefits may not exceed our Allowed Price.

**Supplies**

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

**Orthotics**

You must get Prior Approval for orthotics. If approved, we Cover molded, rigid or semi-rigid support devices that restrict or eliminate motion of a weak or diseased body part.

**Prosthetics**

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

- all or part of an absent body organ (including contiguous tissue and hair);

- hair lost due to chemotherapy or disease (excluding male pattern baldness);
- the lens of an eye; or
- all or part of the function of a permanently inoperative, absent or malfunctioning body part.

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

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

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

Also, we Cover dental prostheses only if required:

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

## Exclusions

We provide no Benefits for:

- prosthetics or orthotics for which you have not received Prior Approval from us;
- dental appliances or dental prosthetics, except as listed above;
- shoe insert orthotics, lifts, arch supports or special shoes not attached to a brace;
- custom-fabricated or custom-molded knee braces (pre-fabricated, "off-the-shelf" braces are Covered);
- dynamic splinting, continuous passive motion equipment (unless you get Prior Approval) and programmable or variable motion or resistance devices;
- any treatment, DME, supplies or accessories intended principally for participation in sports or recreational activities or for personal comfort or convenience; and
- repair or replacement of dental appliances or dental prosthetics except as listed above.

General Exclusions in Chapter Three also apply.

## Note:

To be sure your item meets our definition of Durable Medical Equipment, you may call our customer service team before purchasing a DME item.

## Mental Health Care

You must get Prior Approval for the Services listed on your Outline of Coverage, including all Mental Health Services (except Emergency Services) or your care will not be Covered. We provide Benefits for 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.

We provide Benefits for Inpatient Mental Health care Services including:

- hospitalization; and
- Residential Treatment Programs.

We provide Benefits for Mental Health Services only if:

- you obtain Prior Approval for all Mental Health Services (except Emergency Services) by calling the number on the back of your ID card;
- you receive care from Network mental health Providers;
- care is provided in the least restrictive setting Medically Necessary; and
- there is clear, measurable progress toward a rehabilitative goal, a less restrictive setting or other Medically Necessary goal.

If you are outside Vermont and need Mental Health Services, the above guidelines still apply. The phone number for our mental health Network is on the back of your ID Card. You do not need Prior Approval for Emergency Services. Call as soon as possible after the emergency to arrange follow-up care. When you call, you can get the name of a Provider in our mental health Network.

## Mental Health Exclusions

The plan provides no mental health Benefits for:

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

Remember that the General Exclusions in Chapter Three also apply.

## Cosmetic and Reconstructive Procedures

We exclude many types of Cosmetic procedures (see exclusions in Chapter Three).

You need Prior Approval for the Services listed on your Outline of Coverage, including plastic/Cosmetic or Reconstructive procedures or your care will not be Covered. Your Benefits include Reconstructive procedures that are not just plastic/Cosmetic. (Please see the definitions of Reconstructive and Cosmetic.) For example, we Cover:

- Reconstruction of a breast after breast Surgery;
- Surgery and Reconstruction of the other breast to produce a symmetrical appearance; and

- prostheses (which we Cover under Medical Equipment and Supplies on page 16) and treatment of physical complications resulting from breast Surgery.

## Optometry Services

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

We don't Cover eyeglasses, contact lenses or any examination for the prescription, fitting or determination of need for eyeglasses or lenses unless you need them to replace the lens of the eye and the lens was not replaced at the time of Surgery (see Prosthetics, page 16).

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

## Rehabilitation

You must get Prior Approval for rehabilitation Services.

We Cover:

- Inpatient treatment in a Network Physical Rehabilitation Facility for a medical condition requiring Acute Care.
- Outpatient cardiac or pulmonary rehabilitation for a condition requiring Acute Care.

## Limitations

- We Cover up to three supervised exercise sessions per week up to a total of 36 sessions for cardiac or pulmonary rehabilitation programs.
- For cardiac rehabilitation, we Cover an additional 36 sessions for each new Acute Cardiac Event. You must use a Network cardiac rehabilitation Provider.

## Requirements

The attending Physician must:

- certify that Services of a Physical Rehabilitation Facility are required and are the most appropriate level of care for the condition being treated

- recertify 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:

- care when there is no clear, measurable progress toward a rehabilitative goal, a less restrictive setting or other Medically Necessary goal;
- Custodial Care (see Definitions), as noted in General Exclusions; or
- cognitive retraining 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:

- receive Acute Care in the Skilled Nursing Facility; and
- receive Services from a Participating Skilled Nursing Facility.

### Substance Abuse Services

You must get Prior Approval for all Substance Abuse treatment Services. We Cover the following Acute Substance Abuse treatment Services:

- detoxification;
- Outpatient rehabilitation (including Services for the patient's family when necessary); and
- Inpatient rehabilitation.

### Requirements

We Cover Substance Abuse treatment Services only if:

- you get Prior Approval for all Substance Abuse treatment services;
- you receive care from Network Substance Abuse treatment Providers; and
- you get care in the least restrictive setting Medically Necessary; and

- there is clear, measurable progress toward a rehabilitative goal, a less restrictive setting or other Medically Necessary goal.

The phone number for our Substance Abuse treatment Network is on the back of your ID Card.

### Exclusions

We provide no Substance Abuse treatment Benefits for:

- non-traditional, alternative therapies such as eye movement desensitization, Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required;
- Services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs that focus on education, socialization, delinquency or Custodial Care (see Definitions), as noted in General Exclusions; and
- biofeedback, pain management, stress reduction classes and pastoral counseling. General Exclusions in Chapter Three also apply.

### Therapy Services

We Cover therapy Services provided by:

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

Therapy Services could include the following:

- radiation therapy;
- chemotherapy;
- dialysis treatment;
- Physical Therapy;
- Occupational and Speech Therapy; and

- infusion therapy.

We Cover Occupational, Physical and Speech Therapy only:

- for Physical Therapy Services that require constant attendance of a registered physical therapist, a medical doctor (M.D.), a Chiropractor, an athletic trainer or a doctor of osteopathy (D.O.);
- for up to 30 Outpatient sessions combined per Plan year or up to six months after initiation of therapy for a particular Episode, whichever comes first; and
- when there is clear, measurable progress toward a rehabilitative goal, a less restrictive setting or other Medically Necessary goal.

#### Notes:

- We do not Cover group therapy, group exercise or Physical Therapy performed in a group setting.
- We Cover only Network athletic trainers. We do not Cover Services of Non-network athletic trainers.

## Transplant Services

You must get Prior Approval for transplant Services.

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

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

We pay Benefits for the following Services related to transplants:

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

We pay Benefits for transplants as follows:

- for transplants using a deceased donor, we limit Benefits for the search, removal, storage and transportation of the organ to \$35,000 per solid organ transplant;

- for transplants using a live donor, we limit Benefits for the live donor's surgical expenses and storage and transportation of the organ to \$65,000 for each Covered organ transplant procedure completed;
- if we Cover 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);
- no Benefits are available if we Cover the donor, but not the recipient.

Benefits for transplant-related office visits, labs or Prescription Drugs are subject to the terms and conditions in the other sections of your Contract, including Co-payments and the General Exclusions in Chapter Three.

### Time Period for Recipient Benefits

This section Covers the transplant recipient's expenses directly related to the transplant procedures when they are incurred:

- from 30 days before the procedure to 365 days after the procedure for bone marrow transplants; or
- from five days before the procedure to 365 days after the procedure for all other transplants.

Benefits for transplant-related Services within this time period are subject to the lifetime transplant Benefit maximum listed on your Outline of Coverage.

### Time Period for Living Donor Benefits

We only Cover the costs a donor incurs within 120 days from the date of the donor's Surgery.

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.

The donor expenses are subject to the Deductibles, Co-payments and Co-insurance and terms of the transplant recipient's Contract.

### Exclusions

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

## CHAPTER THREE

# General Exclusions

We may interpret and apply the terms of this Contract. We may determine if you have coverage for certain care. We may also decide how much coverage you have. This applies even when a Provider has prescribed or recommended the Service.

We pay Benefits only for Covered Services described in your Contract. This Certificate and any of your Riders or Endorsements may contain specific exclusions.

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

**Generally, we do not Cover Services and supplies that are not medically necessary.** Also, we do not Cover the following even if they are Medically Necessary:

1. Services that a prior health plan must Cover as extended Benefits.
2. Services you would not legally have to pay if you did not have your Contract or similar coverage.
3. Services for which there is no charge.
4. Services paid directly or indirectly by a local, state or federal government agency, except as otherwise provided by law.
5. Services you require because you committed or attempted to commit a felony or engaged in an illegal occupation.
6. Services over the limitations or maximums set forth in your Contract.
7. Services or drugs that we determine are Investigational, mainly for research purposes or Experimental in nature. However, to the extent required by law, we Cover routine costs for patients who participate in approved cancer clinical trials.
8. Services not provided in accordance with accepted Professional medical standards in the United States.
9. Services beyond those needed to restore your ability to perform Activities of Daily Living (see Definitions) or to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
10. Acupuncture, acupressure or massage therapy; hypnotherapy, rolfing, homeopathic or naturopathic remedies. We Cover Medically Necessary Covered Services when performed within the scope of a naturopathic Physician's license.
11. Electrical stimulation devices used externally. (This exclusion does not apply to bone growth stimulators, transcutaneous electrical nerve stimulation (TENS) devices or neuromuscular stimulators for which you have received Prior Approval.)
12. Automatic ambulatory home blood pressure monitoring or equipment.
13. Biofeedback or other forms of self-care or self-help training.
14. Bulk immunizations (those provided to a Group of people, such as employees in an office setting) or fluoride treatments performed in school.
15. Whole blood, blood components, costs associated with the storage of blood, testing of blood the patient donates for his or her own use (even if the blood is used), transfusion Services for blood and blood components the patient donates for his or her own use in the absence of a Covered surgical procedure. (This exclusion does not apply to blood derivatives and transfusion Services for whole blood, blood components and blood derivatives.)
16. Care for which there is no therapeutic Benefit or likelihood of improvement.
17. Care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the results of treatment or the individual's medical progress.
18. (Routine) circumcision.
19. Clinical ecology, environmental medicine, Inpatient confinement for environmental change or similar treatment.
20. Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading or writing skills. This exclusion does not apply to mandated treatment for autism as defined by Vermont law.
21. Screening colonoscopies except in patients over age 50 or patients with risk factors for colorectal disorders.
22. Communication devices, communication augmentation devices and computer technology or accessories and other equipment, supplies or treatment intended primarily to enhance occupational, recreational or vocational activities, hobbies or academic performance.
23. Consultations, including telephone consultations, except when they occur between Providers and the Providers attach a written report to the patient's medical record.
24. Correction of near- or farsighted 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.

25. Cosmetic procedures and supplies that are not Reconstructive.
26. Custodial Care, Rest Cures.
27. Dental Services and oral Surgery, unless specifically provided by your Contract; procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling).
28. Eyeglasses or contact lenses unless you need them to replace the lens of an eye (and the lens was not replaced at the time of Surgery).
29. Education, educational evaluation or therapy or treatment of developmental delays, therapeutic boarding schools, Services that should be Covered as part of an evaluation for or inclusion in a Child's individualized education plan (IEP) or other educational program. (This exclusion does not apply to treatment of diabetes, such as medical nutrition therapy by approved Network Providers. It also does not apply to mandated treatment for autism as defined by Vermont law.)
30. 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, calluses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet. This exclusion does not apply to necessary foot care for treatment of diabetes.
31. Hearing aids or examinations for the prescription or fitting of hearing aids.
32. Home or automobile modifications or equipment like air conditioners, HEPA filters, humidifiers, stair glides, elevators, lifts, motorized scooters, furniture or "barrier-free" construction, even if prescribed by a Provider.
33. Illnesses or injuries that are:
  - a result of an act of war (declared or undeclared); or
  - sustained in active military service

(**Note:** upon receipt of written request, the Plan will suspend coverage for the military member and make a refund on a pro rata basis for subscription rates paid for the time period the member is in active military service).
34. Infertility Services, including Surgical, radiological, pathological or laboratory procedures or medication leading to or in connection with artificial insemination (intraovaginal, intracervical, and intrauterine insemination), in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any variations of these procedures, including costs associated with collection, washing, preparation or storage of sperm for artificial insemination including donor fees, cryopreservation of donor sperm and eggs. This exclusion does not apply to the evaluation to determine if and why the couple is infertile. We may Cover up to four months of fertility medications per Plan year when you attempt to conceive through natural means (not by artificial insemination, in vitro fertilization, embryo transplantation and gamete intrafallopian transfer, zygote intrafallopian transfer or any variations of these procedures). You must get Prior Approval for the fertility medications.
35. 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.
36. Treatment for willfully uncooperative or intractable patients.
37. Institutional or Custodial Care for the physically or mentally handicapped.
38. Mandated treatment, including court-ordered treatment, unless such treatment is Medically Necessary, ordered by a Physician and Covered under your Contract.
39. Non-medical charges, such as:
  - taxes;
  - postage, shipping and handling charges;
  - a penalty for failure to keep a scheduled visit; or
  - fees for completion of a claim form.
40. Nutritional counseling beyond three visits per Plan Year.
41. Nutritional formulae or supplements, except for up to \$2,500 per year for "medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or formulae and supplements administered through a feeding tube.
42. Orthodontics, including orthodontics performed as adjunct to orthognathic Surgery or in connection with accidental injury.
43. Osteopathic manipulation treatment.
44. Pain management programs.
45. Personal hygiene items.
46. Personal service, comfort or convenience items.
47. Photography Services, photographic supplies or film development supplies or Services (for example, external ocular photography or photography of moles to monitor changes).
48. Physical fitness equipment, braces and devices intended primarily for use with sports or physical activities other

than Activities of Daily Living (e.g., knee braces for skiing, running or hiking); weight loss or exercise programs; health club or fitness center memberships.

49. Pneumatic cervical traction devices.
50. Specialized examinations required by your employer or for sports/recreational activities (e.g., driver certifications, pilot flight physicals, etc.)
51. Support therapies, including pastoral counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy, smoking cessation therapy, stress management, wilderness programs, adventure therapy and bright light therapy.
52. More than one attempt at Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).
53. Telemedicine.
54. Therapy Services provided as a part of chronic pain control, developmental, pulmonary or other form of rehabilitation, except:
  - treatment of diabetes by a Network Provider; or
  - Services for which you have prior written approval by the Plan.
55. Travel (other than Ambulance transport), lodging and housing that is not integral to a Medically Necessary level of care, even if prescribed by a Physician.
56. Treatment leading to, or in connection with, transsexual Surgery.
57. Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
58. Non-prescription-treatment of obesity, except surgical treatment when:
  - your Physician determines that your body mass index is over 40 (according to Table 1 in the "Methods for Voluntary Weight Loss and Control" booklet by the National Institute of Health Technology Assessment Conference Statement of March 1992); and
  - you have other medical conditions that could be significantly and adversely affected by this degree of obesity.

This exclusion does not apply to nutritional counseling Benefits as explained on page 11.

59. Work-hardening programs and work-related illnesses or injuries (or those which you claim to be work-related, until otherwise finally adjudicated), provided such illnesses or injuries are Covered by workers' compensation or should be so Covered. (This provision does not require an individual, such as a sole proprietor or an owner partner to workers' compensation if he or she does not legally need to be Covered.)

60. Services and supplies not specifically described as Covered.

### **Provider Exclusions**

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

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



**CHAPTER FOUR**

# Claims

Remember, when you contact a Provider, you must:

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

## Claim Submission

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

Network Providers will usually submit claims on your behalf if this is your primary coverage (see “Other Party Liability”). When you use Non-network Providers, you must file your own claims.

## Release of Information

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

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

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

## Cooperation

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

## Payment of Benefits

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

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

For information on how we determine your Benefit amount, see Chapter One.

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

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

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

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

## When You Have a Complaint

### Customer Service Help with Complaints

Contact us at the number on the back of your ID card if you have a complaint. Please have your ID card handy when you call. Also, call if you need help understanding our decision to deny you a service or coverage. You can make a medical complaint if you have problems with the

Medical Care or advice that you got from your doctor. You may also make a non-medical complaint. Non-medical complaints might be about:

- BCBSVT Services
- BCBSVT rules
- Waiting times for visits
- After-hours access to your doctor
- The service at the doctor's office

### **If You Don't Agree with Our Decision**

For most types of claims, you are entitled to several levels of review of our decisions:

- You may make a complaint to customer service. This is usually the best first course of action. Our customer service team can solve most problems.
- You may file a grievance. By accepting this Contract, you agree to file a grievance before taking judicial action.
- If you don't agree with our treatment of your grievance, you may file an appeal of the grievance decision. This appeal is voluntary.
- In some circumstances, you may request that the State of Vermont do an independent review of our decision. You do this by calling the State at (800) 631-7788 or (802) 828-2900.
- 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**

A separate reviewer conducts each level of appeal above. Our behavioral health manager handles grievances for Mental Health and Substance Abuse claims. BCBSVT handles second-level appeals of grievances for Mental Health and Substance Abuse claims.

### **Timing of Reviews**

If your review involves Emergency Services or Urgent Care, we will conduct review of your claim within 72 hours. If you believe your situation is urgent, you may request an expedited external review by phone. (All other requests should be in writing.) If you appeal a grievance for Emergency Services or Urgent Care, we will conduct the review within two plan days.

For grievances not related to Medical Care, we will notify you of our decision within 30 days of receiving your request. For all other grievances, we will notify you

of our decision within 60 days of receiving your request. If you appeal your grievance, we will notify you of our opinion within 30 days of your request.

If you're filing a grievance about a denial of Benefits, do so within 180 plan days of when you receive our denial. If you're appealing a decision on a grievance, do so within 90 plan days of our decision.

### **How to Request a Review**

You or someone you name to act for you (your authorized representative) may file a request for any of the levels of review above. Your doctor may serve as your representative. At any time, you can get help with your review from our customer service team. You can also get help from the Vermont Division of Healthcare Administration at (800) 631-7788 or (802) 828-2900.

If your review is not for Emergency Services or Urgent Care, you must request it in writing. Mail it to:

Blue Cross and Blue Shield of Vermont  
PO Box 186  
Montpelier, VT 05601-1086

If you are asking our customer service team to review, send your information to the attention of "Customer Service." If you are filing a first-level grievance, send it to the attention of "Grievances." If you are appealing a grievance, send it to "Voluntary Second Level of Appeals."

If your review is a grievance about a Mental Health or Substance Abuse claim, send it to:

Magellan Health Services  
199 Pomeroy Road  
Parsippany, NJ 07054

If you are appealing a grievance about a Mental Health or Substance Abuse claim, send it to the Blue Cross and Blue Shield of Vermont address above, to the attention of "Mental Health Second-Level Appeals."

### **Information About Your Claim**

Once you start a review, you will receive instructions on how to supply more information. 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.

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## **After Our Decision**

At any point during the 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 no independent authority overturns our decision, you must pay for Services we didn't Cover. Please pay your Provider.

## **Other Resources to Help You**

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

Employee Benefits Security Administration

(866) 444-EBSA (3272)

State of Vermont's Health Care Ombudsman

(800) 917-7787 or (802) 863-2316

Vermont Division of Health Care Administration

(800) 631-7788 or (802) 828-2900.

Of course, our customer service team can help you as well. Call us at the number on the back of your ID card.



**CHAPTER FIVE**

# Other Party Liability

This chapter gives us the right to prevent duplicate payments for a Service that would exceed our Allowed Price 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 our Allowed Price for Covered Services.

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

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

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

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

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

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

## Coordination of Benefits for Children of Divorced Parents

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

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

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

## In an Accident

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

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

## Reimbursement

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

## Medicaid and Tricare

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

## Subrogation

If another person or organization caused or contributed to your illness or injuries, or is supposed to pay for your treatment (such as another carrier) then we have a right to collect back for Benefits provided by this Contract. This is called our "right of subrogation." In this section we will call a person or organization as 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 and liability insurance providing medical Benefits.
- You must cooperate with us and furnish information and assistance that we require to enforce our rights.
- You must take no action interfering with our rights and interests under your Contract.
- If you refuse to pay us or to cooperate with us, we may take legal action against you. We may seek reimbursement from the funds you recovered from a third party, up to the amount of Benefits we paid. If we do, you must also pay our attorney's fees and collection expenses. We may reduce or withhold future Benefits to recover what you owe us.
- You agree that you will not settle your claim against a third party without first notifying us. In some cases, we will compromise the amount of our claim.

## Cooperation

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

Cooperation includes:

- providing us all information relevant to your claim or eligibility for Benefits under this Certificate;
- providing any actions needed to assure we are able to obtain a full recovery of the costs of Benefits we have provided;
- obtaining our consent before providing any release from liability for medical expenses;
- 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, obtain a Group Enrollment Form from your Group Benefits Manager. Fill out the form and give it to your Group Benefits Manager. He or she will submit this request form to us.

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 application 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.

### Birth or Adoption

If you already have a family membership, we Cover your new Child from the date of birth, legal placement for adoption or legal adoption. Please notify us of your family addition within 31 days.

If you do not have a family membership, we Cover your Child for 31 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 application for a membership change to continue Benefits for the Child past 31 days. If we receive your request within the 31 days:

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

If we receive your request within 32 to 60 days, the Child's membership and the new type of membership begins the first day of the month after we receive your request.

## 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 terminates 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.

## Court-ordered Dependents

A court-ordered Dependent's membership begins the first of the month after we receive your request. 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.

## Incapacitated Dependents

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

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

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

We must receive the information within 31 days of the date the individual would lose coverage to avoid interrupting coverage. If we receive the above information more than 31 days after the date the individual would no longer be an eligible Dependent, coverage will begin the first day of the month after we receive the information.

## Removing Dependents

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

- a Dependent dies;
  - the Subscriber and Spouse/Party to a Civil Union divorce
  - a Child turns 26; or
  - the Dependent is no longer Incapacitated
- Dependents become ineligible for coverage at the end of the month after the event occurs.

## Termination of Coverage

### Termination of Coverage by You, by the Group or by Us

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

Upon Contract termination, 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 termination.

### Default in Subscription Payment

If we do not receive your payment on or before the end of the grace period in Chapter Seven:

- We will mail you a cancellation notice.
- This Contract terminates after midnight on the 14th day after we send you a cancellation notice.

We consider a termination for non-payment a cancellation by you.

### Benefits after Termination of Group Coverage

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

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

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

## Fraud, Misrepresentation or Concealment of a Material Fact

If you obtain or attempt to obtain coverage or Benefits through fraud, this Contract is void. You will be permanently disenrolled and all of your family members Covered under this Contract will be disenrolled for 18 months. If a family member committed the fraud, that person will be permanently disenrolled. If you are disenrolled due to fraud, we will not provide any extension of Benefits after this Contract is terminated.

Any falsehood on your application for coverage voids this Contract if discovered within three years of the effective date. After three years of enrollment, only fraudulent misstatements made on your application can be used to void this Contract or as a basis to deny a claim.

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 suit and interest.

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

## Contract Reinstatement

By law, we may reinstate a terminated 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.

## Medicare

Please note that this is not a Medicare supplement Contract. We will not provide Benefits under this Contract if you are Medicare-eligible unless otherwise required or permitted by federal law. Contact your Group Benefits Manager to determine eligibility for the Medicare supplemental Certificate offered through your Group. If you are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Blue Cross and Blue Shield of Vermont.

## Our Pledge to You

Blue Cross Blue Shield of Vermont is committed to customer driven excellence and creating a superior member experience. We will strive to provide highly personalized local service with each and every member interaction. Your opinion of how we execute this pledge is welcomed and valued. We are committed to learn from your feedback and we promise to use your feedback to make meaningful progress and innovative change which you will value.

## Member Rights

As a member, you have the right to:

- Be treated with respect and right to privacy. You should expect that Blue Cross and Blue Shield of Vermont will take measures to keep your health information private and protect your health care records (privacy policy).
- Receive information from us and your Providers. Information we supply will help you understand our organization, your rights and responsibilities as a member, the Network of Providers included in your Plan, and the Services and Benefits available to you and how to use them. Information supplied by your Providers will help you understand your condition and Plans for care.
- Participate with practitioners in making decisions about your health care. In addition, you have the right to engage in candid discussion of appropriate or medically necessary treatment options, regardless of the cost or your Benefits.
- Request out-of-Network Services through the prior authorization process if a practitioner with an appropriate Specialty is not available within your Network to treat a medical condition. We recommend that you coordinate the out-of-Network requests through your Primary Care Physician to help facilitate coordination of care.
- Let us know when you disagree. Your first step when you have a complaint or concern is to call our customer service department. (800-344-6690).
- Recommend changes to us, including to this Member Rights and Responsibilities statement. We want to hear from you if you disagree with

a decision or are unhappy with the care or service you receive.

- Provide feedback on our programs, including our quality improvement and care management programs. You can share your ideas with us by calling our customer service department at (800-344-6690) or emailing [QualityImprovement@bcbsvt.com](mailto:QualityImprovement@bcbsvt.com).
- Access records that we use to make decisions about your health care Benefits. Receive information about your health plan, its Services, practitioners and Providers and members' rights and responsibilities.

As a member, you have the responsibility to:

- Choose a Primary Care Physician.
- Present your ID card each time you receive Services and protect your BCBSVT ID card from improper use.
- Keep your Providers informed and to understand the risk of not giving information others might need to treat you most effectively. For Providers to effectively treat you and manage your care, tell them and others involved in coordinating care about your medical history and current health, and participate in developing treatment goals to the degree possible.
- Treat your Providers and us with respect.
- Keep scheduled appointments and notify your Provider's office ahead of time if you are going to be late or miss an appointment.
- Follow Plan rules and instructions for care. To receive care or Services, you must identify yourself as a member to Providers and follow the policies and procedures described in your Subscriber Certificate and other Plan materials.
- Pay all applicable Co-payments, Co-insurance and Deductibles to your health care Providers, as specified in your Outline of Coverage or Certificate of Coverage.
- Notify the Plan as soon as possible if there is a change in family size, address, and phone number or membership status when you purchase coverage directly from BCBSVT.
- Report such changes directly to the Benefits administrator at the Group in a timely fashion (only applicable if you are insured through a Group plan or employer).

## 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. Signatures must be witnessed by a notary public. You may be required 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 60 days of when the 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

Domestic Partners and their Dependents do not meet the definition of qualified beneficiaries under 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.

Once a Termination of Domestic Partnership form has been submitted, the Subscriber may not include another Domestic Partner on his or her membership for at least nine months from the date Benefits were cancelled.

### Conversion Rights

If the Subscriber becomes employed by another Group that does not have Domestic Partnership coverage or a Termination is filed, the Domestic Partner may convert to available direct-pay coverage in accordance with the Certificate in effect at the time. If both the Subscriber and the Partner convert to direct-pay coverage, they must obtain separate Contracts.

**CHAPTER SEVEN**

# General Contract Provisions

## Applicable Law

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

## Entire Agreement

Your Contract is the Entire Agreement between you and us. You have no rights or privileges not specifically provided in this Contract. We may only change this Contract in writing and with the approval of the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). We will do so in accordance with the law.

## 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 BISHCA.

## Changes in the Subscription Rate

We may change rates only if we receive approval from BISHCA. We will notify your Group of any rate change in accordance with state law.

## Subscription Rate Payments

The subscription rate must be paid in advance directly to us. We allow no more than a 10-day grace period for payment. Your Group Benefits Manager may pay this for you.

## Subscriber Address

You must notify us of any change of address. Call customer service at (888) 882-3600 or mail your change of address to:

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

You may also change your address on our website at [www.bcbsvt.com](http://www.bcbsvt.com).

We send all notices by first class postage to the Subscriber's address on file. This represents our full responsibility to notify the Subscriber, regardless of whether the Subscriber receives the notice.

## Third Party Beneficiaries

All members Covered under this Contract (except the Subscriber) are Third Party Beneficiaries to the Contract.



**CHAPTER EIGHT****Definitions**

**Note:** We have the authority to interpret and apply the terms of this Contract. We may determine if you have coverage for certain care. We may also decide how much coverage you have. This applies even when a Provider has prescribed or recommended the Service.

**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/injury or to obtain rehabilitative potential within a reasonable and medically predictable period of time. Acute Care should be provided in the least restrictive setting. Acute Services means Services which, according to generally accepted Professional standards, are expected to provide or sustain significant, measurable clinical effect within a reasonable and medically predictable period of time.

**Allowed Price:** 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.

**Annual Maximum:** The limit on Benefits we will provide for a particular kind of service in one Plan year. Your Outline of Coverage lists your annual limits. We only impose annual limits on "non-essential Benefits," as defined by the United State Department of Health and Human Services.

**Benefits:** the amount we allow for a Covered Service or supply as shown on your explanation of Benefits. Your Benefit includes amounts applied to Deductible, Co-insurance and Co-payments.

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

**Certificate/Certificate of Coverage:** this document.

**Child:** (see Dependent definition)

**Chiropractor:** a duly licensed doctor of chiropractic, acting within the scope of his or her license.

**Chronic Care:** health Services provided by a health care Professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, asthma, pulmonary disease, Substance Abuse, mental illness, spinal cord injury and hyperlipidemia. Important: We only have Chronic Care Management programs for some of these conditions.

**Civil Union:** a relationship established between two persons of the same sex pursuant to 15 V.S.A. Chapter 23 that entitles the parties to the Benefits and protections of Spouses and subjects them to the responsibilities of Spouses.

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

**Contract:** consists of:

- your Outline of Coverage, this Certificate and the documents listed on your Outline of Coverage;
- your Identification Card; and
- your application and any supplemental applications that you submitted and we approved.

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

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

**Cosmetic:** primarily intended to improve appearance.

**Cover(ed):** describes a Service or supply for which you are eligible for Benefits under your Contract.

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

- help in walking, bathing and other personal hygiene, toileting, getting in and out of bed;
- dressing;

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

**Deductible:** the amount you must pay toward the cost of specific Services each Plan year before we pay any Benefits. Your Outline of Coverage shows your Deductible amounts. (Refer also to Chapter One.)

**Dependent:** a Subscriber's Spouse, the other Party to a Subscriber's Civil Union, or the Subscriber's Child or Incapacitated Dependent (see Chapter Seven) Covered under this Contract.

**Child:** a Subscriber's stepchild (through marriage or Civil Union), son or daughter, 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 coverage has been ordered by a court of law.

**Spouse:** the Subscriber's Spouse under a legally valid marriage.

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

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

- each party is the sole Domestic Partner of the other;
- each party is at least 18 years of age and competent to enter into a Contract in the state in which he or she resides;
- the parties currently share a common legal residence and have shared the residence for at least six months prior to applying for Domestic Partnership coverage;
- neither party is married;

- the partners are not related by adoption or blood to a degree of closeness that would bar marriage in the state in which they legally reside;
- the parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future;
- the parties are jointly responsible for basic living expenses such as the cost of basic food, shelter, and any other expenses of the common household (the partners need not contribute equally or jointly to the payment of these expenses as long as they agree that both are responsible for them); and
- neither party filed a Termination of Domestic Partnership within the preceding nine months.

**Diagnostic Services:** Services, ordered by a Physician or podiatrist, to determine a definite condition or disease.

Diagnostic Services include:

- imaging (radiology, X-rays, ultrasound and nuclear);
- studies of the nature and cause of disease (laboratory and pathology tests);
- medical procedures (ECG and EEG);
- allergy testing (percutaneous, intracutaneous, patch and RAST testing);
- mammography; and
- hearing tests by an audiologist if your doctor suspects you have a disease condition of the ear (see also exclusion number 35 on page 22).

**Domiciliary Care:** Services in your home (or in a home-like environment if you are unable to live alone because of demonstrated difficulties: (1) in accomplishing Activities of Daily Living; (2) in social or personal adjustment; or (3) resulting from disabilities) that are personal care or are designed to help you in walking, bathing and other personal hygiene, toileting, getting in and out of bed, dressing, feeding or with normal household activities such as laundry, shopping and housekeeping.

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

- is primarily and customarily used only for a medical purpose;
- is appropriate for use in the home;
- is designed for prolonged and repeated use; and

- is not generally useful to a person who is not ill or injured.

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

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

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

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

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

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

### **Facility (Facilities):**

the following institutions or entities:

- ambulatory surgical centers
- birthing centers
- community mental health centers
- \*General Hospitals
- \*Home Health Agencies/Visiting Nurse Associations
- \*Physical Rehabilitation Facilities
- \*Psychiatric Hospitals
- \*Residential Treatment Center
- \*Skilled Nursing Facilities
- \*Substance Abuse Rehabilitation Facilities

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

- General Hospital: a short-term, Acute Care hospital that:
  - is a duly licensed institution;
  - primarily provides diagnostic and therapeutic Services for the diagnosis, treatment and care of injured and sick people by or under the supervision of Physicians;
  - has organized departments of medicine and major Surgery; and
  - provides 24-hour nursing Services by or under the supervision of registered nurses.

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

**Group Benefits Manager:** the individual (or organization) who has agreed to forward all subscription rates due under your Contract. The Group Benefits Manager is the agent of the Subscriber. 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.

**Health Care Ombudsman:** The Vermont Health Care Ombudsman provides help to Vermonters who have problems and questions about health care and health insurance through a telephone hotline service. The Ombudsman represents the interests of all Vermont consumers of health care in the legislature and before state agencies.

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

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

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

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

**Include(s), Including:** to have as a part or member of a whole; contain. To put into a Group, class or total. "Include," followed by a list, does not imply the list is complete, unless used with the word "only."

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

**Intensive Outpatient Programs:** programs that have the capacity for planned, structured Service provision of at least two hours per day and three days per week. The Services offered address Mental Health or Substance Abuse-related disorders and could include Group, individual, family or multi-family group psychotherapy, psychoeducational Services, and adjunctive Services such as medical monitoring. These Services would include multiple or extended treatment, rehabilitation or counseling visits or Professional supervision and support.

**Investigative/Investigational:**  
(see Experimental)

**Lifetime Maximum:** the limit on Benefits we will pay for a particular service while you are enrolled with this health plan. Your Outline of Coverage lists your lifetime limits. We only impose lifetime limits on "non-essential Benefits" as defined by the United State Department of Health and Human Service.

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

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

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

**Medically Necessary Care:** health care Services including diagnostic testing, Preventive Services

and aftercare appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition. Medically Necessary Care must be consistent with generally accepted practice parameters as recognized by health care Providers in the same or similar general Specialty as typically treat or manage the diagnosis or condition, and:

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

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

**Mental Health Condition:** nervous or mental condition, only as listed in the Mental Disorders section in the International Classification of Diseases Manual (ICD-9-CM). The following conditions are not considered Mental Health Conditions in this Contract and are Covered under other sections of this Certificate (subject to all terms, limitations and exclusions):

- conditions related to Substance Abuse (see Substance Abuse definition);
  - hyperkinetic syndrome of childhood (ICD-9-CM codes 314.1, 314.2 and 314.8), except for intervention for Acute, brief Episodes when other diagnoses are present;
  - specific delays in development (ICD-9-CM codes 315.00 through 315.99);
  - psychic factors associated with diseases classified elsewhere in the ICD-9-CM (ICD-9-CM code 316.00); and
  - mental retardation (ICD-9-CM codes 317.00 through 319.99), except for interventions for Acute, brief Episodes when other diagnoses are present.
- Mental Health disorders also include only the following nervous or Mental Conditions as listed in the "V Codes" section in the International Classification of Diseases Manual (ICD-9-CM):
- personal history of mental disorder (ICD-9-CM codes V11.00 through V11.99);
  - psychological trauma (ICD-9-CM code V15.40);
  - psychiatric condition (ICD-9-CM code V17.00);

- other family circumstances and other psychosocial circumstances (ICD-9-CM codes V61.00 through V62.99); and
- observation for suspected mental condition (ICD-9-CM code V71.00).

**To find out if your condition is Covered, please call your Network Provider.**

**Mental Health Services:** Services to diagnose or treat a Mental Health Condition.

**Network:** (see Provider)

**Non-Network:** (see Provider)

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

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

**Other Provider:** one of the following entities:

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

**Out-of-pocket Limit:** the out-of-pocket limit is made up of the Deductibles, Co-insurance and all Co-payments (except Prescription Drug Co-payments) you pay. After you meet your out-of-pocket limit, you pay no Co-insurance for the rest of that Plan year. You will still be responsible for Prescription Drugs Co-payments, when they apply.

Your family out-of-pocket limit is listed on your Outline of Coverage. When your family meets the family out-of-pocket limit, all family members are considered to have met their individual out-of-pocket limits.

**Outline of Coverage:** the summary of your Contract Benefits.

**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.

**Parties to a Civil Union:** (see Dependent)

**Pharmacist:** a person who is legally licensed to practice the profession of Pharmacy.

**Pharmacy:** any establishment that is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

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

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

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

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

**Plan:** The Vermont Health Plan, the HMO affiliate of Blue Cross and Blue Shield of Vermont.

**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.

**Network:** (see Provider)

**Prescription Drugs:** insulin and drugs that are:

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

**Preventive Services:** see Screening/Preventive.

**Prior Approval:** the required approval that you must get from us before you receive specific Services noted in your Contract. In most cases, we require that you get

our Prior Approval in writing. We may request a treatment plan or a letter of medical need from your Physician. If you do not get approval from us before you receive certain Services as noted in your Contract, Benefits may be reduced or denied.

**Professional:** one of the following practitioners:

- athletic trainers
- audiologists
- Chiropractors (as further defined in this chapter)
- independent clinical laboratories
- Mental Health Professionals:
  - clinical Mental Health counselors
  - clinical psychologists
  - clinical social workers
  - marriage and family therapists
  - psychiatric nurse practitioners
- nurses:
  - certified nurse midwives or licensed Professional midwives
  - certified registered nurse anesthetists
  - licensed practical nurses (LPNs)
  - nurse practitioners
  - registered nurses (RNs)
- nutritional counselors
- optometrists
- Physicians (as further defined in this chapter)
- podiatrists
- Substance Abuse counselors
- therapists (Occupational, Physical and Speech)
  - Some Providers must be in our Network in order for their Services to be Covered. See Network Providers on page 49.

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

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

**Network Provider:** For most Provider types in Vermont, includes any Provider that has a Network Provider or Participating agreement with us. Includes only Mental Health and Substance Abuse treatment Providers who make an agreement with our behavioral health Network. Includes only Pharmacies who make an agreement with our Pharmacy Benefit Manager. Providers located outside of Vermont are not generally Network Providers. We consider the following providers to be Network Providers

if they participate with their local Blue Cross and/or Blue Shield Plan: cardiac rehabilitation Providers, home infusion therapy Providers, Skilled Nursing Facilities and Physical Rehabilitation Facilities. You may find a Network Provider on our website at [www.bcbsvt.com](http://www.bcbsvt.com). You may also get a directory of Network Providers from your Group Benefits Manager or from our customer service team. Some Providers must be Network in order for their Services to be Covered. For some types of Service, we do not provide Benefits if you do not use a Network Provider. See Choosing a Provider on page 7.

**Non-Network Provider:** a Provider that does not meet the definition of a Network Provider. For some types of Service, we do not provide Benefits if you use a Non-network Provider. They are listed in Chapter One.

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

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

**Quality Improvement:** our program that seeks to improve our service to you and to improve the care you get. For a description, see page 45.

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

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

**Residential Treatment Program:** a 24-hour level of care that provides patients with long-term or severe mental disorders or Substance Abuse-related disorders with residential care. Care is medically monitored, with 24-hour medical availability and 24-hour onsite nursing Services. Care includes treatment with a range of diagnostic and therapeutic behavioral health Services that cannot be provided through existing community programs. Residential care also includes training in the

basic skills of living as determined necessary for each patient.

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

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

**Screening/Preventive:** Screening/Preventive procedures are performed when there is no reason to suspect the presence of disease. Screening procedures are performed for the purposes of early detection and intervention (prevention). We follow national guidelines for the normal frequency for these procedures.

When disease is known to be present, these same procedures are surveillance or diagnostic/therapeutic procedures. When disease has been present in the past, these same procedures may be surveillance and/or diagnostic/therapeutic procedures. What is initiated as a Screening procedure may turn out to be a surveillance or diagnostic/therapeutic procedure if a disease condition is found or suspected during the course of the Screening. In such cases, we pay Benefits based on your Provider's bill and medical documentation, as well as the terms and conditions of your Contract. Depending on the bill submitted by your Provider, you may pay more for a Service that the Provider has determined to be diagnostic rather than Screening/Preventive.

**Services:** health care treatment including but not limited to evaluations, examinations or supplies.

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

- minimal care, Custodial Care, ambulatory care or part-time care Services;
- care or treatment of Mental Health Conditions, Substance Abuse or pulmonary tuberculosis; or
- rehabilitation.

**Speech Therapy:** therapy to correct speech impairment resulting from an Acute disease or occurrence.

**Spouse:** (see Dependent)

**Subscriber:** the individual who enters into this Contract with us.

**Substance Abuse:** Substance Abuse conditions only as listed in the Mental Disorders section in the International Classification of Diseases Manual (ICD-9-CM) as follows:

- alcohol and drug psychoses (ICD-9-CM codes 291.00 through 292.99);
- alcohol dependence syndromes (ICD-9-CM codes 303.00 through 303.99);
- drug dependence (ICD-9-CM codes 304.00 through 304.99); and
- non-dependent abuse of drugs (ICD-9-CM codes 305.00 through 305.99), except tobacco use disorder (ICD-9-CM code 305.10) and other, mixed or unspecified drug abuse (ICD-9-CM code 305.90).

**Substance Abuse Rehabilitation Facility:** a Facility that primarily provides 24-hour rehabilitation treatment seven days per week for Substance Abuse. Facility must offer sufficient availability of medical and nursing Services to manage ancillary detoxification needs. Treatment must follow a written plan. Facilities located in Vermont must be state-approved. Out-of-state Facilities must be accredited by the Joint Commission for Accreditation of Rehabilitation Facilities.

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

**Urgent Services:** those health care Services that are necessary to treat a condition or illness of an individual that if not treated within 24 hours presents a serious risk of harm, or, applying the judgment of a prudent layperson who possesses an average knowledge of health and

medicine, could seriously jeopardize the ability of the individual to regain maximum function, or, in the opinion of a Physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without care within 24 hours.

**Utilization Review:** Review to determine the medical necessity of a service or supply. Utilization Review include Pre-certification, Prior Approval or other cost management programs.

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

**Well-child Care:** normal periodic evaluation of a well child.

**Wellness (Maintenance) Care:** treatment in the absence of an Acute event or a known relapsing or recurring condition that is provided when there are minimal or no current symptoms and which is designed to promote health, enhance quality of life, or prevent the onset over time of future symptoms or disability. Wellness Care is usually provided on a regularly scheduled basis.

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

**CHAPTER NINE**

## 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.

### Newborns' and Mothers' Health Protection Act

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

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

In addition, a Plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain Prior Approval or pre-certification. For information on such requirements of your Contract, please read your Contract documents (Certificate, Outline of Coverage, Endorsements or Riders).

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

## Women's Health and Cancer Rights Act of 1998

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

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

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

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

## Our Quality Improvement Program

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

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

QI studies and projects focus on:

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

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

We also have quality committees with member representatives. If you would like to be on our member quality committee or participate in one of our QI projects, please call our customer service team at the number on

the back of your ID card. Also call if you would like to suggest a change in one of our policies. We keep track of these suggestions. We look at them when writing new policies.

## Information About Your Health Plan

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

Here are examples of information you may want:

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

## Participating in Our Policy Making

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

## Notice of Rights

### Newborns' and Mothers' Health Protection Act

Under federal law, Group health plans and health insurance issuers offering Group health insurance coverage generally may not restrict Benefits for any hospital length of stay in connection with Child birth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending

Provider (e.g., your Physician, nurse midwife or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

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

### Women's Health and Cancer Rights Act of 1998

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

The Women's Health and Cancer Rights Act of 1998 requires that we provide Benefits for reconstruction of the breast on which a mastectomy has been performed and/or the other breast (to produce a symmetrical appearance). We also Cover prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, as required by the Act. Benefits for the above Services are subject to all terms and conditions of your Contract. For example, they require the same Co-insurance, Co-payments and Deductibles as the rest of your coverage. If you have any questions about your rights under this Act, please contact our customer service department at the number on the back of your ID card.

### Notice of Pre-existing Condition Exclusions

This Plan may impose a Pre-existing Condition exclusion. This means that if you have a medical condition before coming to our Plan, you might have to wait a certain period of time before the Plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month

period ends on the day before the waiting period begins. For all members, the Pre-existing Condition exclusion does not apply to a Child who is enrolled in the Plan within 94 days after birth, adoption, or placement for adoption. If you are a member of a Group health plan or Catamount Health, the Pre-existing Condition exclusion also does not apply to pregnancy.

This exclusion may last up to 9 months for members of Group health plans, 12 months if you have individual coverage, and 18 months if you are a late enrollee. These periods begin on your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the Pre-existing Condition exclusion if you have not experienced a break in coverage of at least 90 days (63 days if you have an individual policy). To reduce the exclusion period by your creditable coverage, you should give us a copy of any Certificates of creditable coverage you have. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior Plan or issuer if you request help. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the Pre-existing Condition exclusion and creditable coverage should be directed to the Blue Cross and Blue Shield of Vermont Customer Service Department at P.O. Box 186, Montpelier, Vermont, 05601 or call toll-free (888) 882-3600.

## **Notice of Special Enrollment Rights for Group Health Plan Members**

### ***Loss of Other Coverage***

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

### ***Marriage/Civil Union***

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

If you fail to add your new Dependent within 60 days of your marriage/Civil Union, you must wait until an open enrollment date to do so. If you belong to a small Group (a Group of 50 or fewer employees) plan, check with your Group Benefits Manager to see if your Group or association imposes an open enrollment period.

### ***Birth, Adoption or Placement for Adoption***

If you have a new Dependent as a result of birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents without waiting for the next open enrollment period. If you already have a family membership, we Cover your new Child from the date of birth, legal placement for adoption or legal adoption. You should, however, notify us of your family addition within 31 days. If you do not have a family membership, we Cover your Child for 31 days after:

- birth;
  - legal placement for adoption (when placement occurs prior to adoption finalization); or
  - legal adoption (when placement occurs at the same time as adoption finalization).
- However, we must receive your application for a membership change in order to continue Benefits for the Child past 31 days.

If we receive your request within the 31 days,

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

If we receive your request within 32 to 60 days, the Child's membership and the new type of membership are effective the first day of the month following our receipt of your request.

If you fail to add your new Dependents within 60 days, you must wait until an open enrollment date to do so. If you belong to a small Group (a Group of 50 or fewer employees) plan, check with your Group Benefits Manager to see if your Group or association imposes an open enrollment period. Dependents who do not become Covered within 94 days must fulfill their own waiting periods for Pre-existing Conditions.

To request special enrollment or obtain more information, please contact our customer service department at the number on the back of your ID card or see "Membership" in your Certificate of Coverage.

## Notices of Privacy Practices

### Non-public Personal Financial Information

At Blue Cross and Blue Shield of Vermont, we closely guard all of the personal information we collect about our members. State and federal laws require that we tell you how we protect private information. This particular notice deals with how we treat "financial information." As you might guess, we do not maintain a lot of financial information about our members, but the fact that you are a member of one of our Plans, is, in itself, considered "financial information."

- **Information we collect and maintain:**

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

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

- **Information we disclose:** We may disclose non-public personal financial information about you to our "affiliates." Our affiliates include financial service Providers, such as other insurers, and non-financial companies, such as third party administrators.

In addition, the law allows us to disclose your non-public personal financial information in certain circumstances without providing notice to you and without your authorization. We reserve the right to make those legally permitted disclosures, which may include, but are not limited to, the disclosure of your non-public personal financial information to our affiliates and other parties in order to process claims, coordinate Benefits and accomplish other tasks related to providing you with our Services.

- **No other disclosures to nonaffiliated third parties:**

We otherwise will not disclose non-public personal financial information about our customers or former customers to nonaffiliated third parties except as permitted or required by law.

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

## How BCBSVT safeguards your health information

Our privacy officer has the overall responsibility to implement and enforce privacy policies and procedures to protect your personal health information. You can be assured that every effort is taken to comply with federal and state laws—physically, electronically and procedurally—to safeguard your information. In some situations, where state laws provide greater protection for your privacy, we will follow the provisions of that state law.

We require all of its employees, business associates, providers and vendors to adhere to our privacy policies and procedures under our strictest standards.

## Summary of Protected Health Information Privacy Practices

This summary briefly describes how Blue Cross and Blue Shield of Vermont and The Vermont Health Plan may use and disclose your Protected Health Information (PHI) to carry out payment activities, health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. For a more complete description of how we may use and disclose your PHI, please refer to the Notice of Privacy Practices for PHI,49.

This Notice of Privacy Practices became effective on January 1, 2008 and replaces the previous Notice of Privacy Practices, which became effective on April 14, 2003.

## Our Responsibilities

We are required by law to maintain the privacy of your PHI. In accordance with the HIPAA Privacy Regulations, we have the right to use and disclose your PHI for payment activities and health care operations as explained in the Notice of Privacy Practices. We are most likely to use and/or disclose your PHI for these functions.

Additionally, we may use or disclose your PHI as permitted and required by law. For example, we may use or disclose your PHI for public health activities, legal proceedings or law enforcement purposes.

## Your Rights

You have the following rights regarding your PHI:

- Generally, you have the right to inspect or copy your PHI that is contained in a “designated record set.”
- If you believe that your PHI is incorrect or incomplete, you may request that we amend your information.
- You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment or health care operations.
- You have the right to request that we restrict the PHI we use or disclose about you for payment or health care operations.
- If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location.

**Complaints:** You may complain to us if you believe that we have violated your privacy rights. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

**Communicating with BCBSVT:** Please refer to the following information to inquire about the use of your PHI, to exercise your rights about your PHI or to register a complaint:

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

**Telephone:** (802) 371-3394

**Fax:** (802) 229-0511

**E-mail:** [privacyofficer@bcbsvt.com](mailto:privacyofficer@bcbsvt.com)

## Notice of Privacy Practices for Protected Health Information (PHI)

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

This Notice of Privacy Practices describes how Blue Cross and Blue Shield of Vermont and The Vermont Health Plan may use and disclose your protected health information to carry out payment, health care operations, and for other purposes that are permitted or required by law. It includes our legal obligations concerning your protected health information and describes your rights to access and control your protected health information.

### What is Protected Health Information?

Protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care Provider, a health plan, your employer or a health care clearinghouse, and that relates to: (i) your past, present or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present or future payment for the provision of health care to you. This Notice of Privacy Practices has been written to be consistent with what is known as the “HIPAA Privacy Regulations.”

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact us at the address or phone number provided on the Summary section of this Notice, above.

### Effective Date

This Notice of Privacy Practices became effective on January 1, 2008 and replaces the previous Notice of Privacy Practices which became effective on April 14, 2003.

## Our Responsibilities

We are required by law to maintain the privacy of your protected health information. We are also obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to protected health information and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all protected health information that we maintain. If we

make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the Subscriber of your Contract.

### **Organizations Covered by this Notice**

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

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

These organizations participate in an organized health care arrangement. As such, these organizations may share your protected health information and the protected health information of others they serve with each other as needed for the payment activities and health care operations relating to our organized health care arrangement.

### **Primary Uses and Disclosures of Protected Health Information**

We are most likely to use and/or disclose your protected health information in the following ways:

#### **■ Payment and Health Care Operations**

We have the right to use and disclose your protected health information for all activities that are included within the definitions of “payment” and “health care operations” as set out in the HIPAA Privacy Regulations. Many of these activities are listed below.

#### **■ Payment**

We may use or disclose your protected health information without your permission to obtain premiums or make payments or to otherwise fulfill our responsibilities for coverage and providing Benefits under your Subscriber Contract. For example, we may disclose your protected health information when a Provider requests information regarding you or your Covered Dependent’s eligibility for coverage under our health plan, to issue explanations of Benefits to the Subscriber of the Contract under which you are enrolled, or we may use your information to determine if a treatment that you received was medically necessary.

#### **■ Health Care Operations**

We may use or disclose your protected health information, without your permission, for health care operations functions. These functions include, but are not limited to: quality assessment and improvement, reviewing Provider performance, licensing, business planning and business development. For example, we may use or disclose your protected health information:

(i) to send you information about one of our disease management programs; (ii) to respond to a customer service inquiry from you; (iii) in connection with fraud and abuse detection and compliance programs or (iv) to survey you concerning how effectively we are meeting your health insurance needs. We may use protected health information we receive or maintain, including protected health information such as email addresses or other information that is entered on the [www.bcbsvt.com](http://www.bcbsvt.com) website.

#### **■ Appointment/Service Reminders**

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

#### **■ Business Associates**

We contract with individuals and entities (business associates) to perform various functions on our behalf or to provide certain types of Services. To perform these functions or to provide the Services, business associates will receive, create, maintain, use or disclose your protected health information. We require business associates to agree in writing to Contract terms designed to appropriately safeguard your information. For example, we may disclose your protected health information to a business associate to conduct utilization review activities (i.e. Prior Approval) or to provide member service support or utilization management, or administer Pharmacy claims.

#### **■ Other Covered Entities**

A Covered Entity is defined as: (1) a health plan; (2) a health care clearinghouse; or (3) a health care Provider who transmits any health information in electronic form in connection with a transaction Covered by the Administrative Simplification provisions.

We may use or disclose your protected health information to assist health care Providers in connection with their treatment or payment activities, or to assist other Covered entities in connection with certain health care operations. For example, we may disclose your protected health information to a health care Provider needed by the Provider to render treatment to you. We may disclose protected health information to another Covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. We may disclose or share your protected health information

with other health care programs or insurance carriers to coordinate Benefits if you or your Dependents have Medicare or other health insurance.

### **Potential Impact of State Law**

In some situations, we may choose or be required to follow state privacy or other Applicable Laws that provide individuals greater privacy protections. If a state law requires that we not use or disclose certain protected health information, then we will use or disclose that information according to the applicable state law.

### **Other Possible Uses and Disclosures of Protected Health Information**

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your protected health information:

#### **■ Required by Law**

We may use or disclose your protected health information when we are required to do so by law. For example, we may disclose your protected health information as required by public health disclosure or national security laws.

#### **■ Public Health Activities**

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury or disability. In addition, we may disclose such information to a public health authority authorized to receive reports of Child abuse or neglect. We also may disclose protected health information, if directed by a public health authority, to a foreign government agency that is collaborating with that public health authority.

#### **■ Health Oversight Activities**

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government Benefit programs; (iii) other government regulatory programs; (iv) health insurance carriers; and (v) compliance with civil rights laws.

#### **■ Abuse or Neglect**

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, we may disclose your information to a governmental entity authorized to receive such information, if we believe that you have been a victim of abuse, neglect or domestic violence.

#### **■ Legal Process and Legal Proceedings**

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request or other lawful process, to the extent permitted by the HIPAA Privacy Regulations. For example, we may disclose your protected health information in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Regulations.

#### **■ Research**

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research. In addition, we may disclose your protected health information as part of a limited data set for purposes of research, public health or health care operations.

#### **■ Workers' Compensation**

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide Benefits for work-related injuries or illnesses.

#### **■ Your Group Health Plan or Plan Sponsor (If Applicable)**

If you are Covered under an employer-sponsored Group health plan, we may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors. We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the Group health plan in which you participate or to decide whether to modify, amend or terminate that Group health plan. Summary health information is aggregated claims history, claims expenses or types of claims experienced by

the enrollees in your Group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify protected health information contained in the summary health information as yours.

We may disclose your protected health information to your employer or to a company acting on your employer's behalf, so that it can evaluate, audit or otherwise administer the employee health plan in which you participate. Your employer is not permitted to use this information for any purpose other than administration of your health Benefit plan. See your employer's health Benefit plan documents for information on whether your employer receives confidential information and the identity of the employees who are authorized to receive your confidential information.

#### ■ **Others Involved in Your Health Care**

Using our best judgment, we may make your protected health information known to a family member or an appointed personal representative. Such a use or disclosure will be based on how involved the person is in your care or payment that relates to your care. We may release information to parents or guardians if allowed by law.

We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

If you are not present or able to agree to these disclosures of your protected health information, then, using our Professional judgment, we may determine whether the disclosure is in your best interest.

#### ■ **Public Health and Benefit Activities**

We may use or disclose your protected health information, without your permission, when required by law for the following kinds of public health and interest activities, law enforcement and other public Benefit functions:

- To avert a serious and imminent threat to health or safety;
- To law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies and identifying or locating suspects or other persons;
- To coroners, medical examiners, funeral directors and organ procurement organizations; and

- To the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody.

### **Required Disclosures of Your Protected Health Information**

We are required by law to make the following disclosures:

#### ■ **Disclosures to the Secretary of the U.S. Department of Health and Human Services**

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Regulations.

#### ■ **Disclosures to You**

We are required to disclose your protected health information to you, in accordance with the HIPAA Regulations, in a "designated record set" when you request access to this information. We also are required to provide, upon your request, an accounting of certain disclosures of your protected health information that are made without your authorization and for reasons other than treatment, payment or health care operations.

We will disclose your protected health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose protected health information to such a person, you or the personal representative must submit a written notice of his/her designation, along with the documentation that supports his/her qualification, such as a durable power of attorney for health care.

**Even if you designate a personal representative,** the HIPAA Privacy Regulations permit us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our Professional judgment, that it is not in your best interest to treat the person as your personal representative.

## Your Authorization

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your protected health information for any purpose other than those described in this notice.

## Your Rights

Your rights with respect to your protected health information are as follows:

### ■ Right to Access (Inspect or Copy)

You have the right to inspect or to receive a copy of your protected health information that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care Benefits. However, you may not inspect or receive a copy of psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect or to receive a copy of your protected health information that is contained in a designated record set, you must submit your written request to us at the address listed in the Summary section of this Notice, page 49. Requests sent to persons, offices or addresses other than the one indicated might delay processing of your request. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We will notify you of the cost involved before any costs are incurred.

### ■ Right to Amend

If you believe that your protected health information is incorrect or incomplete, and the information is created by us and/or maintained solely by us, you may request that we amend your information. Your request that we amend your information must be submitted to us in writing at the address provided in the Summary section of this Notice, page 48. Your request should include the reason(s) the amendment is necessary. Requests sent to persons, offices or addresses other than the one indicated might delay processing your request.

We may deny your request for an amendment if, for example, the information you want to amend is not created and/or maintained by us, but by another entity, such as your Physician's office. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

### ■ Right to an Accounting

You have a right to an accounting of certain disclosures of your protected health information that we make without your authorization and for reasons **other than** treatment, payment or health care operations or for certain other activities. Most disclosures of your protected health information will be for purposes of payment or health care operations or made with your authorization.

Your request for an accounting must be submitted to us in writing at the address listed in the Summary section of this Notice, page 48. Requests sent to persons, offices or addresses other than the one indicated might delay processing of your request.

We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you a fee to cover the costs of providing the list. We will notify you of the cost involved before any costs are incurred.

### ■ Right to Request Confidential Communications

If you believe that you may be endangered by a disclosure of all or part of your protected health information through our normal means of communicating with you, you may request that we communicate with you in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or work telephone number. Note, however, that certain communications with you that are normally sent in paper form, such as an Explanation of Benefits (EOB), cannot be communicated to you via telephone or

e-mail, and an alternate address must be supplied if you request confidential communication of your protected health information.

You must submit your request to us in writing at the address listed in the Summary section of this Notice, page 49. Requests sent to persons, offices or addresses other than the one indicated might delay processing the request.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you. Once we receive all of the information related to your request (along with the instructions for handling future communications), the request will be processed as soon as is practicable under the circumstances. Prior to receiving the information necessary for this request, or during the time it takes to process it, protected health information may be disclosed (such as through an Explanation of Benefits, "EOB").

Once a request for confidential communications goes into effect, **all your protected health information** will be processed in accordance with your instructions. This means that we cannot process a request to withhold only the protected health information relating to a specific condition, diagnosis or treatment. Therefore, **all** documents that might contain protected health information about all of the Services you receive (such as letters or EOBs) will be addressed to you and not the Subscriber.

Importantly, even if you request confidential communication, accumulated payment information such as Deductible status, which may contain your protected health information, will continue to appear on all future EOBs sent to the Subscriber for Services rendered by all Providers (Participating and Non-participating).

If you terminate your request for confidential communications, the restriction will be removed for all your protected health information that we hold, including protected health information that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your protected health information will endanger you.

### ■ Right to Request a Restriction

You have the right to request we restrict the protected health information we use or disclose about you for payment or health care operations.

We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

Requests for a restriction must be submitted to us in writing at the address listed in the Summary section of this Notice, page 48. Requests sent to persons, offices or addresses other than the address indicated might delay processing of your request.

### ■ Right to a Paper Copy of This Notice

If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information contained in the Summary section of this Notice, page 48.

## Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information contained in the Summary section of this Notice, page 48.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your protected health information, you may complain to us using the contact information contained in the Summary section of this Notice, page 48. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office of Civil Rights' Hotline at (800) 368-1019.

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

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