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VERMONT



FREEDOM PLAN®

# Vermont Freedom Plan Handbook



**BlueCross BlueShield  
of Vermont**

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

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## How to Use This Booklet

This is your health care **handbook**. It can help you use your health plan. Read here to find out how to get benefits. Use the Table of Contents on the next page to help you find different topics.

## Read Your Contract Too

This booklet *does not* contain all details on what services are covered. You must also read your contract. The contract contains:

- Your **Certificate of Coverage**. It describes covered services and gives requirements and limitations. To find out more about services not covered under your health plan, refer to Chapter Three.
- Your **Outline of Coverage**, which shows what you must pay in co-payments, deductibles, etc. Your **Outline of Coverage** lists services that require Prior Approval. It also lists phone numbers to call to get reviews.
- Any **riders** or **endorsements** listed on your **Outline of Coverage**, which describe additional coverage or changes to your Contract.
- Your **ID Card** and your **Group Enrollment Form (application)**.

If this booklet's language differs from your Contract's language, your Contract's language governs. Please read your Contract carefully.

## Definitions of Terms in Quotes

This handbook has a definitions section. (See the end of the booklet.) It defines insurance terms you may not know. (Those terms appear in quotes in this handbook.)

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## How to Use Your Benefits

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Thank you for choosing the Vermont Freedom Plan (VFP) and Blue Cross and Blue Shield of Vermont. We hope this guide will help you use your VFP health benefits. Whether you are new to VFP or not, please make sure you read all of your documents and know the guidelines for your Plan.

If you have any questions about your benefits, call our customer service department toll-free at (800) 247-2583 or e-mail us from our secure member site at [bcbsvt.com](http://bcbsvt.com). If you need information in another language, customer service can arrange that for you.

Be sure to visit our web site at [www.bcbsvt.com](http://www.bcbsvt.com). You can get information about your benefits there. You can also make transactions like:

- e-mailing customer service
- ordering ID cards or changing your address
- checking claim status
- finding a Preferred or network provider

## Your Responsibilities Under Your Health Plan

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You do not need to choose a Primary Care Physician or get referrals for your care. In order to get the best from your benefit plan, you must follow certain guidelines. You must:

- Make sure you get Prior Approval for certain services (see page 12)
- Understand the difference in coverage for services by Preferred and Non-preferred providers
- Call us when you are admitted to the hospital (see page 13)
- Give your providers the information they need to provide care
- Understand your health problems and participate in creating treatment goals with your doctor, and
- Follow plans and instructions for care you agree upon with your providers

## Our Preferred Provider Network

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With the Vermont Freedom Plan, you may usually select any provider you want to use for a service you need. You pay lower out-of-pocket costs when you use **Preferred** Providers. For some types of services, you must choose a Preferred provider or you will have no benefits. In Vermont, our Preferred network is the same as our Participating Provider network. Some states have Preferred networks that are less extensive than their Participating Provider networks.

For some types of care, like mental health and substance abuse treatment, chiropractic care and pharmacy services, you must choose a **Network** provider or you will have no benefits. Our network provider list is slightly smaller than our list of Preferred Providers. To view our Preferred Provider list and our list of specialty providers, please visit our website at [www.bcbsvt.com](http://www.bcbsvt.com).



When we choose providers for VFP, we check their backgrounds. We use standards of the National Committee on Quality Assurance (NCQA). For more on how we choose providers, see 6. Please understand that none of the providers in our network are employees of BCBSVT. They just contract with us.

## Preferred vs. Non-Preferred Providers

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Vermont Freedom Plan provides two levels of benefits. With Preferred providers you pay only a co-payment for office visits and a deductible and coinsurance (usually 20%) for most other services. Non-preferred provider benefits mean higher costs for you. For most services by a Non-preferred

provider, a higher deductible and higher coinsurance (usually 30%, sometimes 50%) apply. These benefits are separate from your benefits for Preferred providers. For some benefits you must use a Preferred provider to receive any benefits at all. Your *Outline of Coverage* will list what you have to pay for each covered service.

## How We Choose Our Providers

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We choose providers who we feel can provide the best care for our members. VFP doctors are free to see non-BCBSVT patients. Many participate in other health plans.

We look into our providers' backgrounds. We look at their licenses, education and experience. We check for a history of malpractice or fraud. We also visit offices to see if they meet standards for care, access, follow-up, safety and confidentiality. We review providers every three years. If you want information about your provider's education or training, or whether he or she is board-certified please call customer service at (800) 247-2583.

## Our Mental Health and Substance Abuse Treatment Providers

Our mental health and substance abuse care network, Magellan Behavioral Health (MBH), reviews its providers when they join the networks. They conduct follow-up reviews once every three years. MBH is part of a national organization that promotes quality standards.

## Primary Care: First-dollar coverage for office visits

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All Vermont Freedom Plan programs offer coverage for office visits with Preferred providers that is not subject to deductibles and coinsurance. You pay a small co-payment for each visit to a Preferred provider and we pay the rest. (When you use Non-preferred providers for office visits, you must meet your Non-preferred deductible and pay your Non-preferred coinsurance rate.)

The following services fall under your office visit benefits:

- visits to a physician's office for routine or preventive care
- a physician's visits to your home
- physicians' fees for emergency room visits
- allergy injections
- consultations
- second opinions
- certain covered immunizations
- well-baby and well-child care
- approved outpatient mental health and substance abuse visits

## Specialist and Hospital Care

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“Specialty” or “specialist” care is care you receive from a provider other than the doctor you use for primary care services. You do not need referrals from a primary care physician for specialty or hospital care. (For some services, you may need “prior approval” from BCBSVT. See page 12.) For hospital services, you must call for precertification of your stay. (See page 13.) Be sure to use a Preferred provider to receive the most from your health plan. If you go to a Non-preferred provider, you may still receive benefits, but may pay higher out-of-pocket expenses.



## Emergency Services

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In an **emergency**, you need care right away. An emergency occurs when a person with average knowledge of health and medicine expects the condition or illness, if not treated immediately, to result in serious harm to his or her physical or mental health.

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, 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, you must call us as soon as reasonably possible.



## Ambulance Care

We cover emergency ambulance transport. You must get “prior approval” from BCBSVT for water or air ambulance transport and for all non-emergency ambulance services.

## Care Outside the Service Area

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If you have an emergency outside of the service area, your care will be covered. Page 8 tells you what to do if you have an emergency away from home. For other care outside your service area, make sure to use a provider who has a Preferred provider agreement with his or her local plan to receive the highest benefit. (To find Preferred Providers in other states, visit [www.bluecares.com](http://www.bluecares.com) or call 1-800-810-BLUE.) If you see a provider who does not have a Preferred provider agreement with his or her local plan, you will have to pay more of the cost of your care.

## Care After Office Hours

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In most 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" on page 7.

## How to Use Your Mental Health and Substance Abuse Network

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You must get prior approval for all mental health or substance abuse treatment. Call our mental health and substance abuse network, Magellan Behavioral Health (MBH). Dial (800) 395-1356. MBH must give you prior approval. You must use an MBH network provider. (We do not cover services of non-network providers for mental health or substance abuse treatment.)

We list MBH providers in our *Participating Provider Directory*. You may also find an MBH provider on our "Find a Provider" web site at [www.bcbsvt.com](http://www.bcbsvt.com). When you call MBH, you may request a certain provider. But please note, we need both the provider's name and the organization with which he or she participates when you call. Sometimes our networks must make authorizations for particular facilities or community mental health centers rather than to individual providers.

Remember, we only provide mental health or substance abuse treatment benefits when our mental health and substance abuse network approves your care. Check your Contract for details.

For information on how our mental health networks choose providers, please see page 6.

## Open Network Mental Health

If your coverage includes the Open Network Mental Health Rider (see your Outline of Coverage), you do not need Prior Approval. See your rider for rules that apply to your coverage for mental health and substance abuse treatment services.

## Prescription Drugs

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If your Plan has prescription drug coverage, you will have a prescription drug rider listed on your *Outline of Coverage*. The drugs your doctor prescribes must be medically necessary for your problem. We do cover prescription contraceptives. Check your prescription drug rider for drugs we don't cover.

You may have to pay co-payments for drugs. You may also have a deductible and/or coinsurance. (Check your Outline of Coverage.)

We don't limit your coverage to a list of approved drugs, however some drugs aren't covered unless you get prior approval. We list these drugs on your prescription drug rider. See page 12 to learn how to get prior approval. If your prior approval is denied, you can appeal it. See page 19.

Also, you may pay lower co-payments if you use generic drugs or drugs on our Preferred Brand-name List. For the most current list of our Preferred Brand-name drugs, click on the "Rx Center" link from our website, **[www.bcbsvt.com](http://www.bcbsvt.com)**.



We charge one co-payment per refill. One refill may last up to 30 days. Before you travel overseas, you may get a 90-day supply of certain drugs. (In this case, you must pay three co-payments.) Call (800) 247-2583 to do this.

You may also use our mail order drug program. If you do, we may cover a 90-day supply for one or two co-payments. (You may also save co-payments at some retail pharmacies. They must accept our mail order rate.) You should have received a mail order brochure with your Contract materials. If you need a new one, call customer service at (800) 247-2583.

## Blue HealthSolutions Information and Support Program

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Do you have a question about health care? Do you want to know more about an illness or treatment? Blue Cross and Blue Shield of Vermont can help. Our *Blue HealthSolutions* program gives you:

- a self-care handbook
- a 24-hour nurse phone line
- 28,000 web pages on health subjects
- a personalized health information web site

You received a self-care handbook when you joined BCBSVT. (Call customer service at (800) 247-2583 if you still need one.) To use Blue HealthSolutions' web pages, visit BCBSVT's web page at [www.bcbsvt.com](http://www.bcbsvt.com). Call (866) 612-0285 to talk to a Blue HealthSolutions nurse. He or she can tell you more about the Blue HealthSolutions program.

## Maternity Care and “Better Beginnings”<sup>®</sup>

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Your health plan covers maternity care like other services. Your hospital stay is covered like other hospital visits. Be sure to call for admission review for your hospital stay (see page 13). If you are pregnant, call customer service for information on *Better Beginnings*. This program for new parents gives you extra benefits to help you have a healthier pregnancy. We will send you popular books and other materials. Our nurses will call you during your pregnancy. They can help you lower your

risk of having your baby too soon. After you have your baby, we pay for nursing visits in your home. We also pay for homemaker visits to make your first days with your new baby easier. Call (800) 247-2583 for a *Better Beginnings* brochure.

## Care Management

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### Prior Approval

You need prior approval when:

- You use **mental health** or **substance abuse treatment** services, or
- You use services on our “**prior approval**” list (please refer to your *Outline of Coverage* for a list of these services).

For procedures on our “prior approval” list, you **must** receive prior approval or you get no benefits at all.

You must request prior approval in writing. Our team of nurses reviews requests for prior approval. If approval is granted, a nurse does that. If we need to deny approval, a medical director (physician) does that. You may appeal our decision. See page 19.

The prior approval list appears on your *Outline of Coverage*. If you need a new Outline, please contact our customer service department at (800) 247-2583. You may also find our prior approval list in the “Benefits” section of our web site.

All Utilization Management decisions are based on your needs and whether the service is a covered benefit.



## Our Precertification Program

Your plan includes a precertification program. It helps you get the best care at the best value. You must call us when you are admitted to the hospital. Providers may make the calls for you. **The final responsibility rests with you.**

### Preadmission Review

You must call to have a scheduled admission reviewed. Call as soon as possible. We like you to call at least two weeks before you go into the hospital.

A nurse or physician will review your case to see if:

- the admission is medically necessary
- the length of stay is appropriate
- another form of treatment could meet your needs
- another type of facility could meet your needs

For Preadmission Review, please call (800) 922-8778. Your treatment should follow guidelines you receive during your call. Calling us will protect you from having to pay for unnecessary and noncovered stays.

### Admission Review

If you are admitted to the hospital because of an emergency or to have your baby, call us within 24 hours of your arrival or as soon as possible. If a newborn needs to stay in the hospital longer than the mother, call us again within 24 hours after the mother's discharge.

For Admission Review, please call (800) 922-8778. Calling us will protect you from having to pay for unnecessary and noncovered stays.

### Continued Stay Review

While you are in the hospital, nurses review your progress. When you are discharged, the nurses work with you and your doctor to plan continued care.

BCBSVT will notify you in writing if we feel you can safely receive care outside the hospital. That way you can make arrangements to go home. Our case managers will work with you and your doctors to make sure you get the care you need after you leave the hospital.

If you choose to stay longer than your doctor and BCBSVT consider medically necessary, you may have to pay all charges.

### **Who Decides Whether a Stay is Necessary?**

Our team of nurses reviews admissions and procedures for medical necessity. Nurses approve requests for review. If we need to deny an admission or procedure under the precertification program, a medical director (physician) does that.

### **Case Management Program**

Our specialty case management program is a voluntary program available to you. Working with our case management staff, you will receive personalized care-planning by one of our qualified registered nurse case managers. Your case manager will work with you, your family, and your physician to coordinate the medical care most appropriate for you.

Understanding the components of your health plan's coverage can be confusing. Your case manager will work as an advocate, assisting you in managing the benefits you receive through your health plan, as well as identifying other programs, services and support systems available to you.

## **Membership**

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### **Identification Card**

We issue each member his or her own Identification Card. Show it to hospitals and doctors. Carry it always.

### **Beginning Coverage**

The person who handles benefits for your group—your Group Benefits Manager—will tell you when you're eligible. He or she will give you a Group Enrollment Form. Please fill out this form and give it to your Group Benefits Manager. He or she will send it to us. If you have Nongroup

coverage, you will need to fill out a Nongroup Coverage Application and Change Form when you need to make changes to your plan. Send the form directly to BCBSVT.

## If You Should Change Your Address

If you move, please let us know. We need correct records to process your benefits. Fill out a Group Enrollment Form (or a Nongroup Application if you have Nongroup coverage with us). You can get one from your Group Benefits Manager. He or she will forward the form to us. You may also call (800) 247-2583 to make the change. Or change your address on our web site at **[www.bcbsvt.com](http://www.bcbsvt.com)**.

## Continuation of Coverage

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### COBRA

*COBRA rules don't affect employers with fewer than 20 employees or members with Nongroup coverage. Please check the guidelines in "Small Groups and COBRA" to see if your group is exempt.*

You could lose group coverage because:

- you quit your job
- you are laid off
- you enter active military service
- your job status changes
- you are fired
- your company goes bankrupt (but does not cancel the group policy)



If you face losing coverage, COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) may apply. (COBRA doesn't apply if you are fired for gross misconduct.) It requires your employer to keep you and/or your dependents on the group plan for up to 18 months. You must pay for your coverage.

Your employer must tell you of your COBRA rights when you become eligible. To continue your coverage, you must tell your employer you elect COBRA. You must do so within 60 days after one of the events above (or after your employer tells you of your COBRA rights). You must then pay the cost of coverage, plus up to 2% in a service fee.

If you or a dependent are disabled or become disabled within 60 days of the COBRA event (above), you can keep coverage longer. You and your covered dependents may continue for up to 29 months. You must pay a 50% service fee for months 19 to 29.

In other cases, you may keep your coverage for up to 36 months. Please check with your employer or an attorney for more information.

## COBRA for Dependents

Dependents can lose coverage because:

- a child reaches the age of 19 (or 25, if a full-time student)
- a child marries
- you and your spouse divorce
- the subscriber dies
- you become covered by Medicare, but your family needs other coverage

A dependent may have COBRA coverage for up to 36 months. You must elect it within 60 days of the date the dependent becomes ineligible.

## Ending COBRA

Your employer may stop your COBRA benefits after:

- you receive 18, 29 or 36 months of coverage, as explained above
- you don't pay for your first month's coverage within 45 days after you elect COBRA benefits

- you don't pay for later months within 30 days after the date due
- you become eligible for coverage through another group plan (see "COBRA and Pre-existing Conditions" below for an exception)
- your employer cancels the group plan
- you become entitled to Medicare

After you use up COBRA benefits, you may buy individual coverage. (Read the Nongroup Plans section on page 18.)

## **COBRA and Pre-existing Conditions**

COBRA benefits usually end when you can get coverage through another group plan. But your group must keep you if you have not met waiting periods with your new plan. Check with your employer or an attorney for more information.

## **Small Groups and COBRA**

COBRA does not apply to "small" employers (those who employ less than 20 people). For the most part, if your employer had 19 or fewer employees last year, you can't have COBRA if your coverage ends this year. (See "Vermont Continuation of Benefits Law" below.) Some small employers who buy coverage through an association must comply. COBRA requires employers in a "multi-employer arrangement" to comply if one association member has 20 or more employees.

## **Vermont Continuation of Benefits Law**

Vermont law requires your employer to keep you on the group plan after:

- a job loss
- divorce or legal separation
- a job status change
- the death of the subscriber

Vermont law mandates coverage for a shorter time than COBRA. They also require you to take coverage within 30 days of the date you would lose coverage. (COBRA gives you 60 days.) The Vermont law does apply to small employers, though. For more about the state's laws, please see your Group Benefits Manager or an attorney.

## Nongroup Plans

You or your dependents may lose your group coverage because:

- you are not eligible for COBRA or Vermont Continuation of Benefits
- you don't accept these benefits
- you use up these benefits
- your employer or BCBSVT ends this Contract (see notes below)

If you lose group coverage for any of these reasons, you can buy a nongroup plan. You won't have to meet waiting periods.

For continuous coverage, you must call us within 30 days of:

- the end of COBRA or Vermont Continuation of Benefits or
- the date you lose group coverage

You must pay a nongroup rate. It may be higher than the group rate.

- Notes:**
- This is just a brief interpretation of the law as of the printing of this handbook. If you are a group member and have questions, please call your Group Benefits Manager or a lawyer.
  - We can't offer you Nongroup coverage if you are eligible for group coverage or if your group buys coverage from another carrier and that carrier does not accept you.

## Military Service

Are you entering active military service? Your group may stop your coverage while you serve. Apply again within 60 days of your discharge. Your coverage can start again as if no break occurred. If you are injured on active duty, you may have up to two years to re-enroll.

You may also be able to stay on your group's plan while you serve. (See "COBRA.") You must pay for COBRA coverage.

## Filing Claims

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### How to File a Claim

To cover your care, we must get a claim. If you use Participating or Preferred providers, they will file claims for you. If you use nonparticipating providers, you must file claims yourself. You may have to file claims if VFP is secondary to other coverage you have. File your claim within 12 months of when you receive care. Attach a copy of your provider's bill to a claim form and mail to:

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

We usually pay providers directly. Sometimes we will pay you.

**Note:** ■ We make checks in the subscriber's name, not the patient's. We issue you one Explanation of Benefits.

## When You Have a Complaint

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The following sections explain what to do when you don't agree with one of our decisions. Or perhaps you have a complaint or appeal about our service, health plan rules, waiting times to get appointments, after-hours access to your doctor, the service at the doctor's office, or a doctor's care. You may get assistance in any of the following ways. At any time, you may call the Vermont Division of Health Care Administration for help at (800) 631-7788 or (802) 828-2900.

## Complaint (or Inquiry) to Customer Service

Our customer service team can solve most problems. We encourage you to contact customer service before filing a grievance (below) because it may save you time. Contact us at the number on the back of your I.D. card and we will review your complaint. If you wish, another person—perhaps a provider—may call for you. Please have your I.D. Card handy when you call. You may also write to:

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

We resolve complaints as soon as possible. You can make a 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:

- Plan services
- Plan rules
- Waiting times to get appointments
- After-hours access to your doctor
- The service at the doctor's office

## Claim Appeal

You may file an appeal after a customer service review (above) or without one. You have the right to obtain copies of all information related to your appeal. (We suggest you make a complaint to customer service first. This may save you time.) If your appeal is related to Emergency or Urgent Services, you may submit your appeal verbally. All other appeals should be submitted in writing. If needed, we will help you with your appeal. Call customer service at the number on the back of your I.D. card for help.

Send your appeal to:

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

Please be specific about your appeal. If it involves a decision to deny coverage for services, deny eligibility or reduce your benefits, call or write within 180 calendar days of when you receive notice of the denial or reduction in benefits. Once you make a formal appeal, an impartial reviewer will conduct a review to attempt to resolve it. If it is about a decision to deny or reduce benefits, we will see if we should pay your claim.

For an appeal related to medical care not yet rendered, we will complete the review and send you notice of our decision within 30 calendar days of receiving your request for review. For appeals related to medical care you have already received, we will complete the review and send you notice of our decision within 60 calendar days of receiving your request for review. If your appeal involves a request for Emergency or Urgent Services, we will review it and notify you of our decision within 72 hours of receiving your request. For reviews not related to medical care, we will notify you of our decision within 30 days of receiving your request.

### Notes:

- The State of Vermont has a Health Care Ombudsman's office. If you have a problem with your Plan, this office may be able to help. Call (800) 917-7787 or (802) 863-2316.
- By accepting your Contract, you agree to seek a decision of the Claim Appeal Reviewer before taking any judicial action. After you receive our decision, you may choose to pursue a voluntary second level of appeal (below) or, in certain circumstances you may request an independent review with the State of Vermont by calling (800) 631-7788 or (802) 828-2900.
- Your plan may be subject to ERISA. If you are not satisfied with the outcome of the internal-appeal process, and your plan is subject to ERISA, you may have the right to bring legal action under section 502(a) of ERISA. Consult your group benefits manager to determine whether this applies to you. You do not have to submit your claim to the State of Vermont external appeal process prior to filing a suit under section 502(a) of ERISA.

- If you choose to take advantage of our voluntary second level of appeal (below) and still are not satisfied, you will have the right to file an external appeal with the State of Vermont and/or file suit under ERISA (if applicable) as described above after you receive the second level decision.

## Voluntary Second-Level of Appeal

If you are not satisfied with the outcome of the First-Level Appeal, you may file a Second-Level Appeal. The second-level appeal is voluntary and costs you nothing. In some cases, you may choose to file an external appeal with the State of Vermont by calling (800) 631-7788 or (802) 828-2900.

If you choose to file a Second-Level Appeal, you must do so within 90 days after you receive our appeal decision. If your appeal involves a request for Emergency or Urgent Services, you may submit your appeal verbally. All other appeals should be submitted in writing. Give us much information as you can. If needed, we will help you with your appeal. Mail your appeal to:

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

A different reviewer(s) will conduct the second level appeal. You have the right to obtain copies of all information related to your appeal. You or your representative also have the right to meet with the reviewer(s) by phone before we make our final decision. If you are not able to participate by phone, we will make arrangements for you to participate in person.

If your appeal involves a request for Emergency or Urgent Services, we will review it and notify you of our decision within two calendar days of receiving your request for an appeal. For all other reviews, we will notify you of our decision within 30 days of receiving your request for appeal.

If your appeal is denied, you must pay for services we didn't cover. Make your payment to your provider.

## Mental Health and Substance Abuse Complaints

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Mental health and substance abuse complaints (or inquiries) are handled by Magellan Behavioral Health (MBH).

If you have a complaint about mental health or substance abuse care that was denied, call MBH's customer service department at (800) 395-1356. Our customer service team can solve most problems. If you wish, you can ask someone else—perhaps your provider—to call for you. You may also file an appeal. (See below.)

## Mental Health and Substance Abuse Claim Appeal

Mental health and substance abuse appeals are handled by Magellan Behavioral Health (MBH).

You may file an appeal after a customer service complaint (described above). Or you may file an appeal right away. (We suggest you make a complaint to customer service first. This may save you time.) You have the right to obtain copies of all information related to your appeal. If you have an Emergency Medical Condition, we will notify you of our decision within 24 hours of receiving your request. On other appeals about mental health or substance abuse health care we will send you our decision in writing within 10 calendar days of receiving your request. If your appeal is about service (not actual health care), we will resolve it within 30 calendar days of receiving your request.

You must submit your appeal within 180 days of receiving our denial. You may submit an appeal in writing or by phone. Send written appeals to:

Magellan Behavioral Health  
110 Kimball Avenue, Suite 110  
South Burlington, Vermont 05403

Or call (800) 395-1356.

## Appeal of First-Level Decision

You can have a second committee review your appeal if you aren't satisfied with the first decision. The appeal is voluntary and is offered at no cost to you. You have the right to obtain copies of all information related

to your appeal. You, or your representative also have the right to participate by phone or in person. If you choose to file a voluntary appeal, you must do so within 90 days after you receive our decision. To have this review, write to:

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

If you have an Emergency Medical Condition, we will notify you of our decision on your appeal within 24 hours. For all other appeals about health care, we will send you our decision within 30 calendar days of receiving your request.

## Independent Review

Are you dissatisfied with either of our review committees' decisions? After the first review, you have the right to ask the state's Independent Panel of Mental Health Providers to review your case if it involves a denial of services because we think the services are not medically necessary. The panel is not connected to BCBSVT. Or, if you choose to take advantage of our second level of review, and are still not satisfied, you can call the Independent Panel at that time and ask for a review. For more information about the Independent Panel, or to ask for a review, call (800) 631-7788 or (802) 828-3301.



## Vermont's Mental Health Law

Vermont has a law that makes mental health and substance abuse benefits equal to those for other physical problems. Your benefits comply with this law. For a brochure that describes how this law affects you, call (800) 395-1356.

## When You Have to Pay

If your appeal is denied, you must pay for services we didn't cover. Make your payment to your provider.

## Your Health Care Rights

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As a Vermont Freedom Plan member, you have the following rights:

- to be treated with respect, dignity and privacy
- to receive information about your plan, including services and providers
- to help make decisions about your health care
- to voice complaints about the plan or your care
- to make "advance directives," such as living wills
- to have access to your medical records
- to talk candidly about treatment options, regardless of their cost or your benefits
- to make recommendations about our member rights and responsibilities policy

### Note:

- Information about the health care you receive is confidential. We protect this information and we require providers to do so as well. We do not release personal health care information unless we need to do so to process your claims. (For example, if you have more than one health plan, the other carrier may need our reports to coordinate benefits.) For more information about your rights and how we protect them, please refer to your Notice of Privacy Practices that we included with your Contract.

## Information About Your Health Plan

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We will provide you with any information about your health plan, except if we can't by law. Call customer service at (800) 247-2583. Here are examples of information you may want:

- facts about how we choose providers

- 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
- advice on how to get a copy of your medical records

As new technology and drugs become available, we have procedures in place to determine whether we will cover them. The services must be FDA approved. They must be approved by the State of Vermont for use within the state. Research must show the effects of the technology on health outcomes. For more information about the steps we take to decide whether we will cover new technology, call customer service or visit our website, [www.bcbsvt.com](http://www.bcbsvt.com).

You may also be interested in the following topics. You can find information on them in this packet:

- advice on how you can choose a provider (on page 6)
- a list of benefits covered under the plan (see your Contract)
- a description of how drug coverage works (see page 10)
- a description of how the precertification program works (see page 12)
- amounts you must pay (see your Outline of Coverage)
- a guide on how to make a complaint about care or services (see page 19)

Remember, our customer service department is ready to help you with any questions you have. Call (800) 247-2583 from 8 a.m. to 4:30 p.m., Monday through Friday.

## Statement of ERISA Rights

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*(This section does not apply to Nongroup members.)* ERISA, the Employee Retirement Income Security Act of 1974, is a federal law that governs some employee benefit plans. It creates rights for members. It also creates duties for the people who run the plan, the "plan fiduciaries" (PFs). Usually, the PF is your employer.

You have certain rights under ERISA. You may see any of the following without charge:

- insurance contracts
- collective bargaining agreements
- copies of documents filed by the PF with the U.S. Department of Labor, such as annual reports and plan descriptions

You may get copies of any plan information by writing to the PF. The plan may make a reasonable charge for the copies. You may receive a summary of the plan's annual financial report. The PF must furnish each participant with a copy of this summary annual report.

The PF must do so in your interest and in the interest of other plan members.

No one may fire or discriminate against you to stop you from getting a benefit or using your rights under ERISA. If your claim is denied, you must receive a written explanation of the reason. You may have the plan review and consider your claim again.

You can take steps to enforce your rights. If you request documents from the PF and don't receive them within 30 days, you may sue in a federal court. The court might require the PF to provide the materials and pay you up to \$100 a day until you receive them.

If your health plan denies a claim, you may sue in a state or federal court. If the PF misuses the plan's funds or discriminates against you for asserting your rights, you may seek help from the U.S. Department of Labor. Or you may sue in a federal court.

The court will decide who should pay court costs and legal fees. If you win, the court may order the party you have sued to pay them. If you lose, the court may order you to pay them.

If you have any questions about your benefits, contact the PF. If you have any questions about your rights under ERISA, you should contact the U.S. Labor Management Services Administration, Department of Labor.

# Definitions

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## **Emergency Care**

Care you need right away or your health might be in danger.

## **Endorsement**

A Contract document that changes coverage for all Vermont Freedom Plan members.

## **ERISA**

The Employee Retirement Income Security Act.

## **Network**

A group of providers that contract with BCBSVT to provide care to BCBSVT members.

## **Non-Preferred Provider Benefits**

The level of benefits we pay for some services when you use Non-preferred Providers. We may not cover certain services by Non-Preferred providers.

## **Preferred Provider Benefits**

A higher level of benefits you'll receive when you use Preferred Providers. See page 5.

## **Prior Approval**

Approval you get from us before receiving care. Your Contract may require prior approval for some care. For other care, you only need prior approval if you go out of network. You must request prior approval in writing. Our team of nurses reviews requests for prior approval. If approval is granted, a nurse does that. If we need to deny approval, a medical director (physician) does that.

## **Provider**

A doctor, facility, professional or other entity that provides health care to members.

## **Rider**

A Contract document that changes coverage or adds covered services or supplies for some members.

## **We, Us**

Blue Cross and Blue Shield of Vermont or our agent.



## Important Points

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- Read your Certificate, Outline of Coverage, I.D. Card and other Contract materials carefully.
- You must get “**prior approval**” for some care. Otherwise, your care will not be covered.
- We require a **Preadmission or Admission Review** for all hospital admissions. Calling us will protect you from having to pay for unnecessary and noncovered stays.
- **Mental health and substance abuse** treatment benefits don’t cover visits not approved by our network or visits with non-network providers.
- The fact that a provider is a "Participating Provider" with another state's Blue Cross and Blue Shield Plan, does not necessarily make him or her a "**Preferred Provider**" for the Vermont Freedom Plan.

