



*In alliance with
The University of Vermont*

Fletcher Allen Pre-65 Retiree Medical Plan

Plan Document

Effective January 1, 2002

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INTRODUCTION

Your health, you depend on it, try to protect it and, we hope, do not take it for granted. You can do a lot to minimize your chances of illness or injury, but if you need treatment ... you want to know you can get the help you need.

That's why Fletcher Allen Health Care offers medical care benefits to help protect your health with medical care coverage. These benefits can help you get the treatment you need and want ... for your own and your family's health.

Your **Fletcher Allen Pre-65 Retiree Medical Plan** benefits are described in this booklet. A benefit summary, called Medical Plan Highlights, appears in the next few pages.

This booklet provides a description of your Fletcher Allen Pre-65 Retiree Medical Plan benefits; it also serves as the full Plan Document. It does not include details on the medical policies that guide utilization review decisions or claims payment policies. These are available upon request from Vermont Managed Care.

Fletcher Allen reserves the right to amend or terminate the benefits described in this booklet or to change the amount of retiree contributions at any time, to the extent permitted by law.

Benefits described in this document are effective January 1, 2002 and revised on January 1, 2004 and January 1, 2008. Technical terms are capitalized and defined in the Definitions section.

MEDICAL PLAN HIGHLIGHTS

This section provides a benefit summary of your Fletcher Allen Pre-65 Retiree Medical Plan benefits. This benefit summary highlights only some of the many benefits available under your plan. Benefits are subject to change without notice. A more detailed description regarding the terms of coverage, including legislated benefits and exclusions and limitations are provided within this document in later sections.

Co-payments

No co-payments are required for any service.

Emergency Care

No matter where you travel in the U.S. or worldwide, you are covered for emergency care.

Maximum Freedom of Choice

You can choose any licensed medical doctor, specialist, or hospital.

Paperwork Simplified

Your doctor can submit claims directly to the claim office address noted on your ID card. Or, you may file your claims for reimbursement using the claim forms provided by Vermont Managed Care.

FLETCHER ALLEN PRE-65 RETIREE MEDICAL PLAN	
Benefits/Services	Comprehensive
Annual Deductible <ul style="list-style-type: none">• Individual• Family	None None
Annual Out-of-Pocket Maximum <ul style="list-style-type: none">• Individual• Family	None None
Pre-Existing Condition Limitation	Not Applicable
Lifetime Maximum	\$1,000,000

FLETCHER ALLEN PRE-65 RETIREE MEDICAL PLAN	
Benefits/Services	Your Plan Pays
<p><u>Office Visit</u></p> <ul style="list-style-type: none"> • Illness/Injury • Allergy Treatment 	100% up to 20 visits per year
<p><u>Preventive Care</u></p>	100% up to \$500 per year including lab and x-ray
<p><u>Independent X-ray and Lab</u></p>	100% up to \$5,000 per year
<p><u>Prescription Drugs</u></p>	Not Covered
<p><u>Emergency</u></p> <ul style="list-style-type: none"> • Doctor's Office • Emergency Room/Urgent Care Facility • Ambulance 	<p>100%</p> <p>100%</p> <p>100%</p>
<p><u>Hospital Inpatient</u></p> <ul style="list-style-type: none"> • Facility Services • Doctors Visits • Pre-admission Certification/Continued Stay Review 	<p>100% up to 120 days per admission</p> <p>100% [physician charges capped at \$10,000/year]</p> <p>Patient must get approval</p>
<p><u>Outpatient Surgical Facility</u></p>	100%
<p><u>Surgery</u></p> <ul style="list-style-type: none"> • Surgeons Fees • Second Opinion Consultation 	<p>100% up to \$10,000 per year</p> <p>100%</p>
<p><u>Outpatient Rehabilitation</u></p> <ul style="list-style-type: none"> • Includes Physical, Speech, Occupational & Chiropractic Therapy 	100% up to 30 visits per year
<p><u>Special Services</u></p> <ul style="list-style-type: none"> • Skilled Nursing Facility • Home Health Care • Hospice – Inpatient • Hospice – Outpatient 	<p>100% up to 120 days per admission</p> <p>100% up to 120 visits per calendar yr.</p> <p>100% up to 120 days per admission</p> <p>100%</p>
<p><u>Durable Medical Equipment</u></p>	80% up to \$2,000 per year
<p><u>External Prosthetic Appliances</u></p>	100%
<p><u>Mental Health</u></p> <ul style="list-style-type: none"> • Inpatient • Outpatient 	<p>100% up to 120 days per admission</p> <p>100% up to 30 visits per year</p>

FLETCHER ALLEN PRE-65 RETIREE MEDICAL PLAN	
Benefits/Services	Your Plan Pays
<u>Alcohol & Drug Abuse Rehabilitation</u> <ul style="list-style-type: none">• Inpatient• Outpatient	100% up to 30 days per admission 100% up to 60 visits per year
<u>Group Therapy</u>	Subject to Mental Health, Alcohol or Drug Abuse outpatient maximums and limitations
<u>Vision Care</u>	Not Covered

IMPORTANT NOTE:

Coverage is based on a maximum allowed charge that is considered by the Plan to be a Reasonable and Customary charge for the services provided. You may be responsible for balances that remain after the Plan has paid the maximum allowed charge amount.

WHO IS ELIGIBLE

Fletcher Allen offers medical coverage under this Plan to eligible retirees under age 65. Retirees must have been enrolled in an active plan prior to retirement. Members of your family may also be eligible for coverage. Eligible family members include:

- ◆ Your spouse (legally recognized marital partner).
- ◆ Your unmarried natural, adopted or stepchildren or children of whom you have legal custody who are younger than age 19 (age 25 if full-time students) and who are living with you (the Retiree), and are dependent on you (the Retiree) for support. A child is eligible for coverage through the last day of the month during which s/he reaches age 19 (or age 25, if a full-time student). Proof of the child's age and status as a student and dependent must be submitted to the Plan prior to his/her 19th birthday or the date that s/he is enrolled for coverage under the Plan; after that, the Plan may require such proof at least twice each year until s/he attains age 25. Eligibility ends on the date the child is married.
- ◆ Any unmarried physically or mentally handicapped child who cannot work, who is dependent on you for support, and whose handicap began before age 19. A child is considered handicapped if s/he is an unmarried child who is incapable of self-support due to mental or physical handicap. A Physician must certify the physical or mental handicap and the Plan may require proof of certification annually.
- ◆ A child may also include your unmarried child who meets the requirements in one of the above paragraphs, but is not chiefly dependent on you for support or maintenance if the child is recognized under a qualified medical child support order ("QMCSO") as having a right to enrollment under the Plan. Participants can obtain, without charge, a copy of the Plan's procedures governing QMCSOs from the Plan Administrator.
- ◆ Your partner under a Vermont Civil Union.
- ◆ Your surviving spouse if you should die while covered by this Plan.

Any person actively serving in the armed forces of any country is not eligible for coverage under the Fletcher Allen program, except to the extent required by law.

NOTE: *Retirees who are eligible for benefits under this Plan and who are married to (or are a Civil Union partner of) another eligible Fletcher Allen Plan Participant may not be covered under two Fletcher Allen health plans at the same time. If the Retiree and a family member are simultaneously eligible for medical benefits under this Plan or any other medical plan offered by Fletcher Allen, the Retiree and family member must elect coverage under one of the Plans.*

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), an individual may use his or her previous health insurance coverage since July 1, 1996 to reduce or eliminate any preexisting condition exclusion period that might be imposed by a new health plan.

When your Plan coverage ends, you and/or your family members are entitled by law to, and will be provided with, a "Certificate of Creditable Coverage."

Certificates of Creditable Coverage indicate the period of time you and/or your family members were covered under the Plan (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your family members become eligible for coverage under another group health plan, or if you buy a health insurance policy within sixty-three (63) days after your coverage under this Plan ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you and/or your family members under the new group health plan or health insurance policy.

Certificates of Creditable Coverage will be provided automatically to all covered individuals who lose insurance under this health plan when one of the following applies:

- ◆ An individual who is not a COBRA qualified beneficiary – a Certificate will be provided at the time the individual ceased to be covered under the plan.
- ◆ An individual who is a COBRA beneficiary – a Certificate will be provided at the time of the COBRA event, such as divorce or death, no later than the time a COBRA notice is required to be provided for such qualifying event.
- ◆ A COBRA qualified beneficiary who has elected COBRA coverage – a Certificate will be provided at the time COBRA coverage ceases, or, if

applicable, after the expiration of any grace period for the payment of COBRA premiums.

Requests for certificates are permitted to be made by, or on behalf of, any individual enrollee within 24 months after coverage ceases. Call Vermont Managed Care at (802) 847-4862 to request a HIPAA Certificate of Creditable Coverage.

WHEN COVERAGE BEGINS

Retiree medical coverage for you and your family begins on the first of the month following your retirement date. Retirement eligibility means that you are retired from active employment at Fletcher Allen Health Care and, you are at least 55 years of age and you have 15 years of service. You must enroll in the Plan before coverage can begin. Enrollment forms are provided at the time of retirement by the Human Resources Department.

Eligible retirees and family members of an eligible retiree must enroll within thirty-one (31) days of the date they become eligible for the Plan, otherwise they are not eligible to enroll in the Plan, except as described below.

Spouses and stepchildren must enroll within thirty-one (31) days of marriage. Newborn children must be enrolled within thirty-one (31) days of birth. Newborn children are covered automatically for the first thirty-one (31) days if the mother or father is enrolled in the Plan. Adopted children must be enrolled within thirty-one (31) days of the official adoption date or placement for adoption. Coverage for spouses and children will be coordinated with any other medical coverage as described on pages 29-30.

MAKING CHANGES IN YOUR COVERAGE

Before the beginning of each Plan Year, Fletcher Allen reviews the costs associated with maintaining the Plan and will announce the Participant contributions required for medical coverage for the coming Plan Year.

You generally may not change your coverage during the Plan Year unless you experience a qualified change in your family status. Family status changes must be reported within thirty-one (31) days of the event and include (but are not limited to):

- ◆ Your marriage or divorce
- ◆ Birth, change in custody or adoption (including placement for adoption) of a child
- ◆ Changes in your spouse's employment
- ◆ Death or disability of you or a family member covered under the Plan
- ◆ The issuance of a "qualified medical child support order" (QMCSO) from a state court directing the Plan Administrator to provide coverage to a child for benefits
- ◆ Loss of other health coverage

Otherwise, you are not permitted to change your coverage election until the next annual open enrollment period.

HOW MEDICAL COVERAGE WORKS

This is how medical coverage works:

Lifetime and Annual Maximums

The maximum amount of benefit coverage you or each of your covered family members can receive during a lifetime is limited to \$1,000,000. However, some specific areas of coverage are limited per Plan year as follows:

- ◆ Skilled Nursing Facility coverage is limited to 120 days per admission.
- ◆ Mental Health is limited to 30 visits per year for individual therapy, up to 120 days per admission.
- ◆ Office visits limited to 20 visits per Plan year.
- ◆ Preventive Care limited to \$500 per year including lab and x-ray.
- ◆ Laboratory and x-rays limited to \$5,000 per Plan year.
- ◆ Inpatient Hospital limited to 120 days per admission.
- ◆ Physician inpatient professional charges limited to \$10,000 per Plan year.
- ◆ Home Health Care limited to 120 visits per Plan year
- ◆ Hospice Facility limited to 120 days per admission.
- ◆ Mental health inpatient limited to 120 days per admission.
- ◆ Alcohol and Drug Abuse treatment limited to 30 days per admission and/or 60 visits per Plan year.
- ◆ Durable medical equipment limited to 80% up to \$2,000 per Plan year.
- ◆ Outpatient Rehabilitative Services limited to 30 visits per Plan year.
- ◆ Preventive mammograms are limited to one per Plan year with follow up screening if recommended by your physician

Medically Necessary

For benefits to apply, items or services must be Medically Necessary for the diagnosis and treatment of Injury or Sickness and professionally accepted as necessary for your treatment and prescribed or ordered by a Physician or other qualified healthcare provider.

Covered Services

Certain expenses are covered by the Plan, others are not. A detailed list of covered services can be found in the “Covered Services” section of this booklet on pages 16-21. A detailed list of services not covered by the Plan can be found under the “Services Not Covered” section of this booklet on pages 22 - 26. Please call Vermont Managed Care at (802) 847-4862 or (866) 582-6836 for specific questions about coverage.

PRE-APPROVAL PROGRAM

The Pre-Approval program helps you and your family avoid unnecessary services and overly long hospitalization by helping you explore medically appropriate, convenient and less costly alternatives.

Inpatient Pre-Approval and Concurrent Review

Unnecessary hospitalization is costly and can pose needless risks to your health. To help prevent this, non-emergency hospitalizations must be pre-approved through the Pre-Approval program for regular benefit payment at least 5 working days ahead of the admission date, if possible. Ongoing reviews are conducted throughout your Hospital stay to ensure that medical resources are efficiently managed and to control costs. Pre-Approval and ongoing reviews are handled by Vermont Managed Care.

If your Physician recommends that you or a family member be hospitalized, you or your Physician must call Vermont Managed Care for Pre-Approval. **Failure to comply with the Plan's Pre-Approval procedures may result in a loss of coverage under the Plan.**

***Call Vermont Managed Care to obtain Pre-Approval
for a Hospital stay at (802) 847-4862 or toll free at (866) 582-6836
24 hours a day, 7 days a week to receive coverage under the Plan***

Vermont Managed Care's telephone number is printed on the back of your health care identification card. In the case of an emergency admission, you or your Physician must call Vermont Managed Care within 48 hours of admission. If you ask your Physician or someone else to call Vermont Managed Care for you - and that person fails to do so - you may be responsible for any financial penalties imposed by the Plan.

Pre-Approval Program

The concurrent review program nurses will conduct ongoing reviews with your Physician throughout your Hospital stay. If you need to exceed the agreed length of Hospital Confinement, you or your Physician must notify Vermont Managed Care before the original agreed length of Hospital Confinement ends in order to request additional days. The Plan pays regular benefits only for the length of stay approved by Vermont Managed Care. Benefits for unapproved Hospital stays may be reduced.

When you call Vermont Managed Care, please have the following information ready:

- ◆ Patient's address, phone number, Social Security number and birth date
- ◆ Retiree's name, Retiree's address, phone number and Social Security number
- ◆ Physician's address and phone number
- ◆ Diagnosis
- ◆ Name, phone number and address of the Hospital or outpatient procedure center
- ◆ Planned admission date

Please be prepared to indicate the reason for your request and any supporting medical information: i.e., lab work, radiology, clinical notes and/or consultation reports.

Inpatient Claims Involving Urgent Care

For Pre-Approval requests for inpatient admission Claims Involving Urgent Care (but which do not constitute emergency care), Vermont Managed Care will notify you and your Physician of the Pre-Approval decision within 72 hours of receipt of the request for admission. If Vermont Managed Care does not receive all of the information necessary to consider the request for Pre-Approval, Vermont Managed Care will notify you and your Physician of the information needed to complete its review. Within 24 hours of receipt of the

requested information, Vermont Managed Care will notify you and your Physician of the Pre-Approval decision.

If your Hospital admission is not approved, you or your Physician may appeal the decision. See the “Appeals Policy” section of this booklet on pages 52 - 58 for instructions on appeals.

COVERED SERVICES

The term “covered services” means the services received by a Participant that meets the requirements for coverage under the Plan. Charges incurred for such services are considered covered services to the extent that the services or supplies provided are recommended by a Physician or for Emergency Services, and are Medically Necessary for the care and treatment of any Injury or a Sickness. The following list includes the services and supplies covered by the Plan:

- 1) **Ambulance** emergency transportation of the sick or injured.
 - ◆ Charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
 - ◆ Between facilities, when Medically Necessary.
- 2) **Chiropractic Care**
Charges made by a licensed chiropractor for professional services.
- 3) **Durable Medical Equipment (DME)**
DME which is Medically Necessary for the care of a Sickness or Injury.
DME may be rented or purchased.

The equipment must meet the following criteria:

- it is manufactured solely to serve a medical purpose; it is not primarily for comfort or convenience,
- it is ordered by a Provider working within the scope of his/her license,
- it is generally not useful to a person in the absence of Sickness or Injury,
- it is appropriate for use in the home, and
- it can stand repeated use.

◆ Exclusions – including but not limited to:

- hearing aids;
- air conditioners, humidifiers, dehumidifiers or purifiers, HEPA filters;
- arch supports, shoe insert orthotics, corrective shoes
- blood pressure machines or cuffs;
- heating pads, hot water bottles, disposable items (i.e., rubber gloves);
- sterile water, distilled water;
- deluxe equipment (e.g., motor driven wheel chair or beds), when standard equipment is adequate;
- rental or purchase of equipment, when in a facility which provides such equipment;
- disposable supplies, unless otherwise specified in this document;
- stair chairs;
- physical fitness, gym memberships, exercise equipment including isotonic and isometric devices, and ultraviolet/tanning equipment;
- home modifications (i.e., lifts, chair glides, and “barrier-free” construction), and
- breast pumps.

4) **Emergency Services**

Emergency Services are covered at a licensed facility to the extent that they are Medically Necessary. If a Participant visits an emergency room for non-Emergency Services, no benefits will be provided. The Plan reserves the right to retrospectively review services received in an emergency room to determine whether they were Emergency Services.

5) **Genetic Counseling**

The Plan will provide coverage for charges related to genetic counseling.

6) **Home Health Care**

The Plan will provide benefits as detailed in the Schedule of Benefits (pages 3 - 5) for home health care charges made by a Home Health Care Agency for the following covered necessary services or supplies provided to a Participant who is homebound:

- ◆ Part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a Nurse;
- ◆ Part-time or intermittent home health aide services; which consist primarily of caring for the patient when skilled services are also in place and excluding custodial care services;
- ◆ Physical therapy, occupational therapy, speech therapy and social work provided by the home health care agency; and
- ◆ Medical supplies, laboratory services and medications prescribed by a physician, to the extent such items would have been covered under this Plan if the covered person had been confined in a Hospital.

Limited to 120 visits per calendar year.

7) **Hospice Care**

Charges made for a person who has been diagnosed as having six months or less to live, due to Terminal Illness. The following services are covered under a hospice care program:

- by a hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a psychologist, social worker for individual or family counseling including bereavement counseling;
- by a Home Health Care Agency for:
 - part-time intermittent nursing care by or under the supervision of a Nurse;
 - part-time intermittent services of a Home Health Aide;
 - physical therapy, occupational therapy, speech therapy services provided as comfort measures;
 - Durable Medical Equipment;
 - social worker services;
 - IV/SC therapies for hydration, pain management and/or antibiotics;
 - epidural pain control;
 - continuous care nursing services;
 - respite, homemaker services, custodial services.

8) **Hospital Inpatient Care**

Room and board and other Medically Necessary services and supplies, including inpatient professional visits, surgery, anesthesia, diagnostic x-rays, laboratory charges, chemotherapy, blood transfusions, oxygen therapy, physical therapy, occupational therapy, speech therapy, or respiratory therapy.

9) **Hospital Outpatient Care**

Coverage for charges for Medically Necessary surgery, treatment, supplies and professional services received as an outpatient.

10) **Infertility**

- ◆ For diagnostic testing and evaluation leading to the diagnosis of infertility.
- ◆ Medically Necessary surgical corrective procedures.

11) **Mastectomy**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Therefore, the following deductibles and coinsurance apply: 20% co-insurance on Durable Medical Equipment. Refer to the Medical Plan Highlights section of this booklet on pages 2-4. If you would like more information on WHCRA benefits, call the Plan Administrator at 802-847-4862 or toll-free at 1-866-582-6836.

12) **Maternity and Newborn Services**

The Plan will pay maternity benefits, including treatment for false labor and toxemia of pregnancy, as well as complications from pregnancy. Covered services may be provided by a medical doctor, osteopath or nurse midwife participating in the Vermont Managed Care network.

Group health plans and health insurance issuers generally may not, under federal law, 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Plan covers a newborn child of you or your spouse from the moment of birth for 31 days and pays benefits for medically diagnosed congenital defects, birth abnormalities and prematurity. The Plan also pays for the initial inpatient examination by a doctor other than the delivering doctor or the doctor who administered the anesthesia. **To continue the child's medical coverage, you must enroll the child for coverage within 31 days of birth.**

13) **Mental Health/Alcohol and Drug Treatment**

- ◆ Inpatient Mental Health Therapy
 - maximum annual benefit for treatment in a licensed facility is 120 days per admission
- ◆ Outpatient Mental Health Therapy
 - maximum annual benefit is 30 visits
- ◆ Inpatient Alcohol and Drug Abuse Therapy
 - maximum annual benefit for treatment in a licensed facility is 30 days per admission
- ◆ Outpatient Alcohol and Drug Abuse Therapy
 - maximum annual benefit is 60 visits

14) **Nutritional Counseling**

Medically necessary visits with a certified nutritionist or dietetic counselor

15) **Office Visits**

- ◆ Professional service provided in an office, injections, and pre- and post- natal care.
- ◆ Consulting Physicians, second opinions.

16) **Rehabilitation Services**

- ◆ Inpatient:
 - for all services provided by a licensed acute or sub-acute rehabilitation facility.
- ◆ Outpatient:
 - for services of physical therapy, occupational therapy, and speech therapy .
 - maximum benefit 30 visits combined per year.

17) **Skilled Nursing Facilities (SNF)**

For inpatient services including:

- room and board, including nursing care;
- medications provided by SNF;
- all medical services and supplies are included in the pre-established rates of the SNF limited to 120 days per admission.

18) **Transplant Services**

- ◆ Charges made for, or in connection with approved solid organ transplant services, including immuno-suppressive medication, organ procurement costs and donor costs, balance of charges which are not covered by the donor's medical insurance plan.
- ◆ Charges made for stem cell or bone marrow transplant services.

SERVICES NOT COVERED

Certain expenses are not covered by the Plan and, therefore, are ineligible for payment under the Plan. The following list includes the services and supplies not covered by the Plan.

- 1) **Acupuncture and Other Alternative or Complementary Therapeutic Practices**, including, but not limited to acupressure, massage therapy, hypnotherapy, and homeopathy.
- 2) **Air Ambulance**, when ground ambulance will meet the medical need.
- 3) **Amniocentesis and Ultrasound** or any other procedures requested solely for sex determination of a fetus.
 - ◆ **Exception:**
 - Where Medically Necessary to determine the existence of a sex-linked genetic disorder.
- 4) **Charges in excess of Reasonable and Customary Charge as determined by the Plan.**
- 5) **Charges submitted by a Provider who is rendering care to himself/herself or his/her family member.**
- 6) **Charges which the Participant is not legally required to pay.**
- 7) **Charges which would not have been made if the Participant had no insurance.**
- 8) **Charges for services not listed under the Covered Services Section of this booklet.**
- 9) **Circumcision**
 - ◆ **Exception:**
 - if Medically Necessary.

10) **Cosmetic and Reconstructive Surgery**

◆ **Exception:**

- to restore function of any body area which has significant impairment from disease, trauma, congenital/ developmental anomalies or previous therapeutic processes.
- reconstructive surgery following a mastectomy, including surgery and reconstruction of the unaffected breast, for the purpose of achieving symmetry or as otherwise required by federal law.

11) **Costs** related to your failure to keep appointments with providers.

12) **Court Ordered Treatment**

13) **Custodial Care and Personal Comfort Items**, including but not limited to personal care kits, television and telephone rentals.

14) **Dental Care and Oral Surgery**, including dental surgery, dental appliances, dental prosthesis, such as crowns, bridges or dentures; implants, orthodontic care, operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies, treatment of dental cavities, gingivitis, periodontal disease or other periodontal surgery; vestibuloplasties, alveoplasties, dental procedures involving teeth and their bone or tissue supporting structures, frenulectomy or other dental procedures.

◆ **Exception:**

- facility and anesthesia charges related to the extraction of bone-impacted wisdom teeth when it is medically necessary to have the extraction done at a hospital, subject to Pre-Approval.
- dental work directly related to an Injury to sound natural teeth (does not include Injury to natural teeth resulting from chewing).

15) **Disposable Medical Supplies**

- 16) **Experimental or Investigational** treatments, procedures, devices or prescriptions.
 - ◆ **Exception:**
 - new technology when written pre-approval is obtained by the Participant from the Medical Director.
- 17) **Foot Care; Routine** in connection with corns, calluses, non-Medically Necessary pedicures.
- 18) **Hearing Exams and Hearing Aids** and their fitting or hearing device implants.
- 19) **Home Birth** charges in connection with home birthing services.
- 20) **Infertility**, artificial insemination, in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) or any services connected with the above.
- 21) **Medical Foods**, infant formulas and over-the-counter nutritional supplements.
- 22) **Non-Medically Necessary Services**
- 23) **Occupational Therapy, Physical Therapy and Speech Therapy** for long term, non-acute medical conditions including but not limited to behavioral problems, developmental delays, learning disabilities, mental retardation, hyperkinetic syndromes, and autism.
- 24) **Orthotics**, shoe insert orthotics or, custom-made orthotics.
- 25) **Outpatient Services** provided in a facility, which are routinely provided in an office setting.
- 26) **Over-the-Counter Disposable or Consumable Supplies** or convenience items, including but not limited to devices, AC/DC converters for CPAP, air casts, ace bandages, corsets, etc.
 - ◆ **Exception:** ostomy supplies.
- 27) **Physical Examinations** including, but not limited to employment, insurance, government license, court-ordered, forensic, driver or pilot's license and travel.
- 28) **Prescription Drugs**

29) **Private Duty Nursing Services**

30) **Private Hospital Rooms**

◆ **Exception:**

- when medical necessity is determined by the attending Physician

31) **Reversal of Tubal Ligation**

32) **Reversal of Vasectomy**

33) **Services Rendered by Non-Providers** Services rendered by a facility, professional, lay provider or other person or entity that is not licensed to provide services for the treatment of Sickness or Injury.

34) **Smoking Cessation Programs**

35) **Therapy to Improve General Physical Condition**, including, but not limited to weight reduction programs and physical fitness programs.

◆ **Exception:**

- cardiac and pulmonary rehabilitation for medical conditions.

36) **Transsexual Surgery and Related Services**, including hormone therapy.

37) **Travel and Housing Expenses**

38) **US Government Owned Facilities** Charges for Sickness or Injury connected with military service, past and present, except where such coverage is mandated by law.

39) **Vision Care**, including routine vision care, eyeglasses, contacts, magnification vision aids, charges for tinting, anti-reflective coating, prescription sunglasses or light-sensitive lenses, safety glasses or lenses required for employment, or the fitting of such items, routine refraction, radial keratotomy, or any surgery for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error, or vision training.

◆ **Exception:**

- the treatment of medical eye conditions;
- the first pair of lenses or glasses, following cataract surgery if an intra ocular lens was not surgically implanted;
- Medically Necessary items in connection with Injury to the natural eye.

40) **Whole Blood, Plasma, Cells and Other Blood Derivatives**, if participation in a volunteer blood replacement program is available to you.

FILING CLAIMS

In most cases, you will need only to show your Fletcher Allen Pre-65 Retiree Medical Plan identification card and the Provider will file your claim for you. After the medical claim has been processed, you will receive a written notice showing what benefits have been paid and what charges, if any, remain to be paid. This written notice is called an Explanation of Benefits.

For some charges, such as medical equipment or other charges billed to you directly, you will need to file a claim yourself. Plan benefit payments for these charges will be made directly to you unless you specifically request that it be made to the provider. If you are in doubt as to whether you need to file a claim, ask the Provider that furnished the services.

Claims must be filed within 120 days of the date the expense was incurred.

Claims filed after this period will not be honored. Submit claim forms, receipts and itemized bills showing the Plan member who received the care or service, the Provider, and the date and type of service received to:

Medical Services

Vermont Managed Care
c/o Apex Benefit Services
PO Box 3620
Akron, OH 44309-3620

A separate claim form is required for each member of your family. You may want to keep a copy of all bills and receipts, along with a copy of the completed claim form, for your records. Fletcher Allen Pre-65 Retiree Medical Plan claim forms for Vermont Managed Care are available from the Human Resources Department, or by calling the number on the back of your identification card.

If all or any part of your claim is denied, within 30 days of receipt of your claim the claims administrator will send you an Explanation of Benefits for your

claim. In special circumstances, it may take more than 30 days to send an Explanation of Benefits. If an extension is needed, you will receive written notice of the extension before the end of the 30-day period. In no event will the extension be more than 15 days.

The Explanation of Benefits will give specific reasons for the denial, reference the specific Plan provisions on which the denial is based, describe any additional material necessary for you to resubmit your claim, explain the Plan's review procedures, and provide a description of the appeal procedures and applicable time limits. The Explanation of Benefits will also include a statement of your right to bring a lawsuit under ERISA following an adverse benefit determination on review. If the claims administrator relied on a rule, protocol or guideline in reviewing your claim, it will offer to give you a copy of the applicable rule, protocol or guideline upon request. If the claim was denied based upon a lack of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the plan is available upon request at no charge.

See the "Appeals Policy" section of this booklet on pages 52 - 58 for information on how to appeal denied claims.

COORDINATION OF BENEFITS

In many families, family members may be covered by more than one medical plan. Each plan pays benefits, but the plans coordinate their payments so that the total combined payments under all of the plans are not more than 100% of the allowable amount. This is the benefit maximum under the Plan. In no circumstances, will the benefits payable under this Plan, when added to the benefits paid under the other plan, exceed the amount payable under this Plan. Coordination of Benefits (COB) rules determine the sequence of payments. One plan has primary responsibility and pays first; the other plan has secondary responsibility and pays benefits for any covered expenses not paid by the primary plan subject to any benefit maximums under the terms of the secondary plan. The following sets forth the order of benefit determination of this Plan when there are multiple benefit plans:

- 1) Non-dependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person as a dependent is secondary.
- 2) Child covered under more than one plan. The primary plan is the plan of the parent whose birthday is earlier in the year if the parents are married, the parents are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that has covered either of the parents longer is primary. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but the parent's spouse does, the spouse's plan is primary. If the parents are separated (whether or not married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order among the plans is as follows:
 - The plan of the custodial parent;

- The plan of the spouse, if any, of the custodial parent;
 - The plan of the non-custodial parent, and then
 - The plan of the spouse, if any, of the non-custodial parent.
- 3) Active or inactive employee. The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- 4) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's family member) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- 5) Longer or shorter length of coverage. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.

NOTE: *In any event, this Plan will not provide benefits as a secondary plan, such that benefits paid, including benefits paid under the other plan, exceed benefits payable under this Plan. In addition, the Plan will not pay for any item or service for which it would not provide benefits under this Plan in the absence of coverage under the other plan.*

SUBROGATION/REIMBURSEMENT

The rules set forth in this section apply to any Sickness or Injury which is:

- Caused by an act or omission of a third party; or
- Covered under medical payment provisions of a liability or automobile policy issued to or otherwise covering you or your family member.

If you or your family member receives or is entitled to receive payment from any person, organization or entity in connection with an Injury or Sickness or for care for which benefits were provided or will be provided under the Plan, the Plan, or its designee, may recover the amounts it pays or will pay, up to the sum received from or on behalf of the third party.

By your and your family member's participation in the Plan and in consideration for the benefits the Plan provides, you and your family member shall agree to grant the Plan, or its designee, a lien on all funds you or your family member recover up to the total amount of benefits provided by the Plan. The Plan or its designee may give notice of that lien to any party who may have contributed to your or your family member's loss.

By your and your family member's participation in the Plan and in consideration for the benefits the Plan provides, you and your family members agree that the Plan or its designee shall be subrogated to your and your family member's rights to the extent of the benefits provided under the Plan. This includes the Plan's, or its designee's, right to bring suit or file claims against the third party in your or your family member's name.

You and your family members agree to take actions, furnish information and assistance, and execute such instruments as the Plan or its designee may require in order to enforce rights under this section. Before the Plan pays any benefits relating to an Injury or Sickness which may have been caused by a third party, it may require you and/or your family member to sign papers confirming the Plan's right to repayment. You and your family members agree not to take any action which prejudices the Plan's or its designee's rights and interests under this section. If you or your family members do not cooperate in the Plan's or its designee's administration of this section, the Plan will **not** provide coverage for the Sickness or Injury. In addition, you or your family members will be responsible for any legal expenses the Plan or its designee incurs to enforce rights under this section.

The Plan reserves the right to deduct any amounts due the Plan pursuant to this section from future benefit payments for you and your family members.

WHEN COVERAGE ENDS

Your medical coverage will end:

On the earliest date of one of the following events:

- ◆ If you fail to make the required contribution for medical coverage;
- ◆ If Fletcher Allen stops offering retiree medical coverage;
- ◆ On the date on which you or a family member falsify information, misrepresent a material fact, utilize fraud or deception for the use of Plan services, or knowingly permit such deception by another person;
- ◆ On the date you are no longer an eligible Fletcher Allen retiree under age 65.

Coverage for your family or family member will end:

- ◆ As outlined above; or,
- ◆ At the end of the month when your family member no longer qualifies as an eligible family member (see “Who is Eligible” section in this booklet on pages 5-6 for the definition of eligible family member); or,
- ◆ If you fail to make the required contribution for family medical coverage; or,
- ◆ If Fletcher Allen stops offering family medical coverage for pre-65 retirees.

CONTINUATION OF COVERAGE-CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

In some cases, you or your family members have the option in accordance with federal law (COBRA) to continue coverage beyond the time it would normally end by paying the full cost of coverage. The following sets forth a list of events that may qualify you or your family members to obtain continuation coverage and the duration of continuation coverage you and/or your family members may be able to receive.

If...

You divorce or legally separate...

You die...

Your covered child no longer qualifies for coverage...

Fletcher Allen files for bankruptcy. . .

Then...

Coverage for your covered family members can be continued for up to 36 months

Coverage for your covered family members can be continued for up to 36 months

Coverage for the child can be continued for up to 36 months

Coverage can be continued until your death (or the death of your surviving spouse); coverage can be continued for your spouse and dependent children for up to 36 months after your death

To be eligible for this continuation coverage, you or your family members must be covered under this Plan on the day before the qualifying event. You can also obtain continuation coverage for children born to, adopted by or placed for adoption with you during your continuation coverage.

You or your family members must notify Fletcher Allen within 60 days of your separation or divorce, or when your covered child becomes ineligible for medical coverage, or, if later, within 60 days of the date coverage under the Plan would end for you or your family members.

After Fletcher Allen is informed of such qualifying events or becomes aware of other events, they will notify their Third Party Administrator who will send enrollment forms within 30 days directly to the person eligible for continuation coverage. Included with the enrollment forms will be information about your and/or your family members' rights to continue coverage and the costs of this coverage.

Following notification from Fletcher Allen's Third Party Administrator of your and/or your family members' eligibility for continuation coverage, in order to obtain such continuation coverage, you and your family members must elect the coverage within 60 days after plan coverage would otherwise end, or, if later, within 60 days after the date of notice by Fletcher Allen's Third Party Administrator of continuation coverage rights. The failure to elect continuation coverage within this period will result in loss of continuation coverage rights.

You and/or your covered family members must pay the full cost as allowed by law for continuation coverage. Generally, this will be 102% of the cost of providing medical coverage under the Plan (or, in the case of an extension of continuation coverage due to a disability, 150%, provided the disabled individual elects the extension). After notifying Fletcher Allen's Third Party Administrator of your intent to continue coverage, you and/or your family will have a 45-day period in which to pay the costs for the initial month of continuation coverage. Thereafter, costs for continuation coverage must be paid by the date specified by Fletcher Allen's Third Party Administrator. Although payments are due on the dates specified by Fletcher Allen's Third Party Administrator, you will be given a grace period of 30 days to make each monthly payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before

the end of the grace period for that payment. The failure to make the initial or any subsequent payments in accordance with the due dates established by Fletcher Allen's Third Party Administrator will result in cancellation of coverage.

Continuation coverage under COBRA will end on the earlier of:

- ◆ The date the maximum period of continuation coverage expires.
- ◆ The first day for which timely payment of the required cost for continuation coverage is not made.
- ◆ The date upon which Fletcher Allen no longer offers medical coverage to its pre-65 retirees.
- ◆ The date upon which you or a family member becomes covered under any other group health plan that does not exclude or limit coverage for a pre-existing condition that you or your family may have.

No other continuation or conversion of coverage rights apply, except as are specifically set forth under the Plan.

DEFINITIONS

1) **Acute**

A sudden or abrupt change in your health that requires treatment expected to produce improvement within a reasonable and predictable period of time.

2) **Alcohol and Drug Abuse**

Conditions related to the excessive use or misuse of alcohol or drugs leading to a dependence or, the use of drugs (including alcohol) for non-therapeutic effect especially one for which it was not prescribed or intended with the potential for physical, social or psychological harm.

Conditions as listed in the Mental Disorders Section in the International Classification of Diseases Manual (ICD-9-CM) as follows:

1. Alcohol and drug psychosis;
2. Alcohol dependence syndromes;
3. Drug dependence;
4. Non-dependent abuse of drugs, except tobacco use disorder and other, mixed or unspecified drug abuse.

3) **Benefit Maximum**

The limit placed on Plan payments for certain procedures or services. A Benefit Maximum can:

1. Apply to specific benefit categories or to all benefits;
2. Apply to a specific time period, such as annual or lifetime.
Whenever the term “lifetime benefit maximum” appears, it refers to the time you or your dependents are covered under the plan.

4) **Charges**

The term “charges” means the actual billed charges; except when the Participating Provider has contracted directly or indirectly with the Plan for a different amount.

5) **Chronic Care**

Care that is not likely to produce measurable improvement in a reasonable and predictable length of time.

6) **Civil Union Partner**

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.

7) **Claim Involving Urgent Care**

Any claim for inpatient Hospital services with respect to which the application of the time periods for Pre-Approval of inpatient Hospital services

1. Could seriously jeopardize your life or health or your ability to gain maximum function, or
2. In the opinion of your Physician, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

8) **Custodial Services**

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including mental illness, alcohol or drug abuse). Custodial Services include, but shall not be limited to:

1. Services related to watching or protecting a person;
2. Services related to performing or assisting a person in performing any activities of daily living, such as:
 - a) walking
 - b) grooming
 - c) bathing
 - d) dressing
 - e) getting in or out of bed
 - f) toileting
 - g) eating
 - h) preparing foods; or
 - i) taking medications that can usually be self-administered; and
3. Services not required to be performed by trained or skilled medical or paramedical personnel.

9) **Durable Medical Equipment**

The term Durable Medical Equipment means equipment which is prescribed by a Provider and:

1. Is primarily and customarily used to serve a medical purpose;
2. Is generally not useful to a person in the absence of Sickness or Injury;
3. Is appropriate for use in the home; and
4. Can withstand repeated use.

10) **Emergency Services**

Emergency Services are medical, surgical, Hospital and related health care services, including ambulance service, required for the alleviation of severe pain or to treat an Injury or a sudden, unexpected onset of a serious Sickness such that a prudent layperson with an average knowledge of health and medicine, could reasonable expect that, if not treated immediately, may result in serious medical complications, loss of life, permanent impairment of bodily functions, or which may otherwise be determined by Plan, in accordance with generally accepted medical standards, to have been an acute condition requiring immediate medical attention.

11) **Expense Incurred**

An expense is incurred when the service or the product incurred is provided.

12) **Experimental/Investigative**

A drug, device, medical treatment or procedure that is determined by the Plan to meet one or both of the following criteria in relation to the condition for which it is being dispensed or rendered:

The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished or reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials may be necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence includes, but is not limited to, published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

13) **Home Health Aide**

The term Home Health Aide means a person who:

1. Provides care of a medical or therapeutic nature; and
2. Reports to and is under the direct supervision of a Home Health Care Agency.

14) **Home Health Care Agency**

The term Home Health Care Agency means a Hospital or a non-profit or public home health care agency which:

1. Primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Nurse;
2. Is run according to rules established by a group of professional persons;
3. Maintains clinical records on all patients; and
4. Does not primarily provide custodial care or care and treatment of the mentally ill.

But only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

15) **Hospice Facility**

The term Hospice Facility means an institution or part of it which:

1. Primarily provides care for terminally ill patients;
2. Is accredited by the National Hospice Organization;
3. Meets standards established by; and
4. Fulfills any licensing requirements of the state or locality in which it operates.

16) **Hospital**

The term Hospital means:

1. An institution licensed as a hospital, which:
 - a) maintains, on the premises, all facilities necessary for medical and surgical treatment;
 - b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and
 - c) provides 24-hour service by Registered Nurses;
2. Maintains daily clinical records on each patient and has available at all times the services of a Physician under an established agreement;
3. Other institutions including: rehabilitative Hospital, Hospice Facility or ambulatory surgical care center which operates primarily to provide elective surgical care and admits and discharges each patient within a working day.

17) **Hospital Confinement**

A person will be considered confined in a Hospital if s/he is:

1. A registered bed patient in a hospital upon the recommendation of a Physician; or
2. 2 days partially confined, which equals 1 day of confinement. (The term “partially confined” means continually treated for at least 3 hours but not more than 12 hours in any 24-hour period.)

18) **Injury**

The term injury means an accidental act that harms or damages.

19) **Medicaid**

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

20) **Medical Director**

A physician who is employed by or contracted to conduct utilization review determinations for Vermont Managed Care. The Medical Director has overall authority for the Utilization Management Plan and the provider Credentials Plan.

21) **Medically Necessary**

Services or supplies received from a qualified Provider that are required to identify or treat a Sickness or Injury. These services or supplies must be directed and supervised by a Physician, consistent with the symptom or diagnosis and medical practice, and be the most appropriate supply or level of service with regard to a member's safety. Service or supplies that are solely for the convenience of a Participant or a Provider are not considered Medically Necessary when specifically applied to an inpatient hospital stay. Medically Necessary also means that the Participant's condition could not be treated safely on an outpatient basis or alternative treatment setting.

22) **Medicare**

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

23) **Mental Illness**

The term mental illness means any disorder, other than a disorder induced by alcohol or drug abuse, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to a mental illness will not be considered to be charges made for treatment of a mental illness.

24) **Nurse**

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N.," or "L.V.N."

25) **Participant**

The term Participant includes Retirees and family members who meet the Plan's eligibility requirements, or who are eligible for continuation coverage under COBRA and who have elected coverage under the Plan.

27) **Physician**

The term Physician means a licensed medical practitioner (other than nurse practitioner) who is practicing within the scope of his/her license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if s/he is:

1. Operating within the scope of his/her license; and

2. Performing a service for which benefits are provided under this plan when performed by a Physician.

28) **Plan**

The Fletcher Allen Pre-65 Retiree Medical Plan.

29) **Plan Year**

January 1 - December 31

30) **Pre-Approval**

The process in which proposed medical services are reviewed by the Care Management Department and a determination is made regarding the medical necessity of the proposed treatment.

31) **Prescription Drug**

Prescription Drug means:

1. A drug which has been approved by the Food and Drug Administration for safety and efficacy; or
2. Certain drugs approved under the Drug Efficacy Study Implementation review; or
3. Drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a prescription order, or
4. Injectable insulin.

32) **Provider**

A facility, professional or other provider that is qualified through education and training and is licensed to provide services for the treatment of Sickness or Injury, where required, and is acting within the scope of that practice.

33) **Psychologist**

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychologist association. It will also include:

1. Any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if s/he is:
 - a) operating within the scope of his/her license; and

- b) performing a service for which benefits are provided under this plan when performed by a Psychologist: and
- 2. Any psychotherapist while s/he is providing care authorized by the Provider Organization if s/he is:
 - a) state licensed or nationally certified by his professional discipline; and
 - b) performing a service for which benefits are provided under this plan when performed by a Psychologist.

34) **Reasonable and Customary Charge**

A charge will be considered Reasonable and Customary if:

- 1. It is the normal charge made by the provider for a similar service or supply; and
- 2. It does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by the Plan.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

35) **Retiree**

The term Retiree means an individual who has met the requirements for retirement as defined within the Fletcher Allen Health Care Retirement Plan.

36) **Room and Board**

The term Room and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

37) **Sickness**

The term Sickness means a physical illness or Mental Illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

38) **Skilled Nursing Facility**

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

1. Physical rehabilitation on an inpatient basis; or
2. Skilled nursing and medical care on an inpatient basis;

But only if that institution:

- a) maintains on the premises all facilities necessary for medical treatment;
- b) provides such treatment, for compensation, under the supervision of Physicians; and
- c) provides nursing services 24 hours per day.

39) **Terminal Illness**

An illness will be considered a Terminal Illness if a person becomes ill with a prognosis of six months or less to live, as diagnosed by a Physician.

ERISA RIGHTS

As a Participant in the Fletcher Allen Pre-65 Retiree Medical Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

You may submit a written request to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or family members if there is a loss of coverage under the Plan as a result of a qualifying event. You or your family members may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one may discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal

court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN INFORMATION

Name of Plan

- ◆ Fletcher Allen Pre-65 Retiree Medical Plan

Plan Sponsor

- ◆ Fletcher Allen Health Care
111 Colchester Avenue
Burlington, VT 05401
(802) 847-2825

Employer Identification Number

- ◆ 03-0219309

Plan Number

- ◆ 501

Type of Plan

- ◆ Group Health Plan

Type of Administration

- ◆ The Plan is administered by the Plan Sponsor, which has contracted with the claims administrator to process claims and to perform other administrative functions.

Type of Funding

- ◆ The Plan is funded by Fletcher Allen through Fletcher Allen and Participant contributions.

Plan Administrator

- ◆ Fletcher Allen Health Care
111 Colchester Avenue
Burlington, VT 05401
(802) 847-2825

To the extent permitted by applicable law, the Plan Administrator has the responsibility to apply and interpret the Plan at its sole discretion.

Claims Administrator

- ◆ Vermont Managed Care
c/o Apex Benefit Services
P.O. Box 3620
Akron, OH 44309-3620

Agent for Service of Legal Process

- ◆ Director of Compensation and Benefits
Fletcher Allen Health Care
111 Colchester Avenue
Burlington, VT 05401
(802) 847-2825

Service of legal process may also be made on the Plan Administrator.

Plan Year

- ◆ January 1 to December 31

Amendment or Termination

While Fletcher Allen expects to continue the coverage described in this booklet indefinitely, it reserves the right to amend or terminate this coverage at any time, for any reason, to the extent permitted by law.

APPEALS POLICY

Vermont Managed Care Medical Appeals

Vermont Managed Care, Inc. administers a process for Fletcher Allen Pre-65 Retiree Medical Plan members to appeal denial of coverage decisions.

The purpose of this process, by which you or your family member or your or your family member's authorized representative (collectively referred to as you or your throughout this section), is for you to appeal denial of requests for Pre-Approval of services, reduction or termination of concurrent care, or retrospective claim denials made by Vermont Managed Care. A retiree may appeal denial of requests for Pre-Approval of services, reduction or termination of concurrent care, or claim denials made by Vermont Managed Care for his/her own claims and services, and his/her family members' claims and services. A family member may also appeal denial of requests for Pre-Approval of services, reduction or termination of concurrent care, or claim denials made by Vermont Managed Care for his/her own claims. Vermont Managed Care will only review one person's appeal for each denial of request for Pre-Approval of services, reduction or termination of concurrent care, or claim denials made by Vermont Managed Care. For example, if the Retiree appeals a denial and the family member later appeals the same denial, Vermont Managed Care will only address the first appeal and will reject the appeal by the family member as a duplicate appeal.

A family member may terminate the Retiree's authority to appeal denial of requests for Pre-Approval of services, reduction or termination of concurrent

care, or claim denials made by Vermont Managed Care for the family member pursuant to this section by notifying Vermont Managed Care in writing of such termination.

All decisions on appeal will be in writing and will include the following information: the specific reason(s) for the determination; reference to the specific plan provision(s) on which the determination is based; a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge; a statement of your right to bring a lawsuit under ERISA Section 502(a) following an adverse benefit determination on review; if an internal rule, guideline or protocol was relied upon, a statement that the rule, guideline or protocol is available upon request at no charge; if the determination was based on a lack of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your claim. If your final appeal is ultimately denied in whole or in part, you have the right to file a lawsuit under the Employee Retirement Income Security Act of 1974 (ERISA).

Because the appeals process varies depending on the type of denial, the policy is divided into four sections: denial of requests for Pre-Approval of Claims Involving Urgent Care, denial of requests for Pre-Approval of all other claims, reduction or termination of concurrent care claims, and denial of claims for which services have already been provided.

Denial of Requests for Pre-Approval of Claims Involving Urgent Care

◆ *First Appeal*

Upon receipt of written or verbal notice from Vermont Managed Care of a denial (in whole or in part) of a request for Pre-Approval of a Claim Involving Urgent Care, you may submit a request (verbal or written) appealing the denial. Be sure to state why you believe the claim should not have been denied, a description of the medical circumstances that exist which require review as a Claim Involving Urgent Care, and submit any data, questions or comments you think appropriate. Upon your request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information the claims administrator has relating to your request for Pre-Approval of a Claim Involving Urgent Care. Your appeal will be reviewed by Vermont Managed Care. If Vermont Managed Care determines that your claim is not a Claim Involving Urgent Care, your appeal will be handled in accordance with the procedures for denial of requests for Pre-Approval of all other claims, or denial of claims for services which have already been provided (both set forth below), whichever is applicable.

A decision on the first appeal of a Claim Involving Urgent Care will be made by Vermont Managed Care within 72 hours after receipt of your request for review.

Vermont Managed Care may notify you verbally of its decision and will also send its decision in writing. If the appeal is denied, the written notice will include the specific reasons for the decision, specific references to the appropriate Plan provisions on which the decision is based, and your right to appeal the denial.

◆ *Second Appeal*

Upon receipt of written or verbal notice from Vermont Managed Care of a denial (in whole or in part) of your first appeal of a denial for request for Pre-Approval of a Claim Involving Urgent Care, you may submit a request (verbal or written) appealing the denial. Be sure to state why you believe the claim should not have been denied, a description of the medical circumstances that still exist which require review as a Claim Involving Urgent Care, and submit any data, questions or comments you think appropriate. Upon your request and free of charge, you may have

reasonable access to, and copies of, all documents, records, and other information the claims administrator has relating to your request for Pre-Approval of a Claim Involving Urgent Care, and your first appeal. Your appeal will be reviewed by the Vermont Managed Care, Care Management Committee. The Care Management Committee is a committee of Vermont Managed Care's Board of Directors, and is comprised of physicians, none of which will have been involved in the original denial of your claim or review of your first appeal.

If Vermont Managed Care determines that your second appeal does not relate to a Claim Involving Urgent Care, your appeal will be handled in accordance with the procedures for denial of requests for Pre-Approval of all other claims, or denial of claims for services which have already been provided (both set forth below), whichever is applicable.

A decision on the second appeal of a denial of a Claim Involving Urgent Care will be made by Vermont Managed Care within 72 hours after receipt of your request for review.

Vermont Managed Care may notify you verbally of its decision and will also send its decision in writing. If the appeal is denied, the written notice will include the specific reasons for the decision as well as specific references to the appropriate Plan provisions on which the decision is based. The notice will also include any further legal rights you may have with respect to the denied appeal, including any right to bring a civil action under federal law.

Denial of Requests for Pre-Approval of Claims Other than Claims Involving Urgent Care

◆ *First Appeal*

Upon receipt of written notice from Vermont Managed Care of a denial (in whole or in part) of a request for Pre-Approval of a claim, you may submit a written request appealing the denial. Be sure to state why you believe the claim should not have been denied, and submit any data, questions or comments you think appropriate. Upon your request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information the claims administrator has relating to your request for Pre-Approval of a claim. Your appeal will be reviewed by Vermont Managed Care.

A decision on the first appeal will be made by Vermont Managed Care within 30 days after receipt of your request for review.

Vermont Managed Care will send written notice of its decision. If the appeal is denied, the written notice will include the specific reasons for the decision, specific references to the appropriate Plan provisions on which the decision is based, and your right to appeal the denial.

◆ *Second Appeal*

Upon receipt of written notice from Vermont Managed Care of a denial (in whole or in part) of your first appeal of a denial for request for Pre-Approval of a Claim other than a Claim Involving Urgent Care, you may submit a written request appealing the denial. Be sure to state why you believe the claim should not have been denied, and submit any data, questions or comments you think appropriate. Upon your request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information the claims administrator has relating to your claim and first appeal. Your appeal will be reviewed by the Vermont Managed Care, Care Management Committee. The Care Management Committee is a committee of Vermont Managed Care's Board of Directors, and is comprised of physicians, none of which will have been involved in the original denial of your claim or review of your first appeal. Your appeal will be reviewed at a meeting of the committee and you may attend the meeting to provide information in support of your second appeal. The committee will then make a decision on your appeal.

You will receive a written decision on your second appeal within 30 days after receipt of your request for review. If the appeal is denied, the written notice will include the specific reasons for the decision as well as specific references to the appropriate Plan provisions on which the decision is based. The notice will also include any further legal rights you may have with respect to the denied appeal, including any right to bring a civil action under federal law.

Denial of Claims for Concurrent Care

If Vermont Managed Care has approved an ongoing course of treatment to be provided over a period of time or for a certain number of times and Vermont Managed Care reduces or terminates care authorized as part of the ongoing course of treatment, Vermont Managed Care will notify you sufficiently in

advance of such reduction or termination to reasonably allow an appeal and determination by Vermont Managed Care on your appeal. The written notice will give specific reasons for the reduction or termination, reference the specific plan provision on which the reduction or termination is based, describe any additional material necessary for you to resubmit your claim, and explain the Plan's review procedures. If Vermont Managed Care relied on its rules, protocols or guidelines in reviewing your claim, it will give you a copy of the applicable rule, protocol or guideline upon request.

You or your authorized representative may submit a request appealing the reduction or termination. You must appeal the reduction or termination of services within a reasonable time after receiving notice. Be sure to state why you believe the services should not have been reduced or terminated, and submit any data, questions or comments you think are appropriate. Upon your request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information Vermont Managed Care has relating to the reduction or termination. Your appeal will be reviewed by Vermont Managed Care.

If the appeal of the reduction or termination of concurrent care qualifies as a Claim Involving Urgent Care it will be handled in accordance with the policy set forth in this section above. Otherwise, appeals of reductions or terminations of concurrent care will be handled in accordance with the policies set forth in this section for denial of requests for Pre-Approval of a claim other than Claims Involving Urgent Care, or denial of a claim for services already provided, whichever is applicable.

Denial of Claims for Which Services Have Already Been Provided

◆ First Appeal

Within 180 days of receiving written notice of a claim denial (in whole or in part), you or your authorized representative may submit a written request appealing the claim denial. Be sure to state why you believe the claim should not have been denied, and submit any data, questions or comments you think are appropriate. Upon your request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information the claims administrator has relating to your claim. Your appeal will be reviewed by Vermont Managed Care. A decision on the first appeal will be made by Vermont Managed Care within 60 days after the receipt of your request for review. The decision on the review will be in writing and will include the specific reasons for the decision, specific references to the appropriate Plan provisions on which the decision is based, and your right to appeal the denial.

♦ *Second Appeal*

If after Vermont Managed Care reviews your appeal and the denial is upheld, you have the right to a second level of appeal. The second level of appeal will be reviewed by the Vermont Managed Care Care Management Committee of the Vermont Managed Care Board of Directors, a committee comprised of physicians that will review your second level appeal. Members of this committee will not have been involved in the denial or review of your original appeal. You or a representative may attend this meeting to provide information in support of your appeal. The committee will make a decision and you will be notified in writing of the outcome of the appeal within 30 days.

The decision of the Care Management Committee at the second level is final.

Imposition of any Co-payment requirements by a Participating Provider at the time of the service and pursuant to the Participating Provider's Network contract and this Plan, is not a denial of request for Pre-Approval of services, reduction or termination of concurrent care, or claim denial made by Vermont Managed Care and is not subject to the appeals process described in this section.

The Vermont Managed Care Care Management Committee may at its sole discretion designate a subcommittee to review appeals for benefit exclusions or limitations.

HIPAA PRIVACY NOTICE

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice. This notice is distributed to you annually and is available from the Plan Privacy Officer.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact Barbara Drapola, Privacy Officer, Vermont Managed Care.

If you wish to file a request to the health plan to not use or disclose health information, or if you wish to file a complaint under HIPAA, you may do so by contacting the Director of Operations/Privacy Officer, Vermont Managed Care.

HIPAA SECURITY STANDARDS

This Section addresses Fletcher Allen Health Care's obligations as the Plan Sponsor with respect to the security of Electronic Protected Health Information.

I. Definitions

- A. Electronic Protected Health Information – The term “Electronic Protected Health Information” (“EPHI”) has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information (or “PHI”) that is transmitted or maintained in any electronic media.
- B. Plan – The term “Plan” means the Fletcher Allen Pre-65 Retiree Medical Plan.
- C. Plan Documents – The term “Plan Documents” means the group health plan's governing documents and instruments, including but not limited to the Fletcher Allen Pre-65 Retiree Medical Plan Summary Plan Document.
- D. Plan Sponsor – The term “Plan Sponsor” means the entity as defined at section 3 (16)(B) of ERISA, 29 U.S.C. § 1002(16)(B). The Plan Sponsor is Fletcher Allen Health Care.
- E. Security Incidents – The term “Security Incidents” has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful authorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

II. Plan Sponsor Obligations

Where EPHI will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the EPHI as follows:

- A. Plan Sponsor shall, implement administrative, technical, and physical safeguards (“Safeguards”), that reasonably and appropriately protect the integrity, confidentiality, and availability of EPHI that the Plan Sponsor creates, transmits, maintains, or receives on behalf of the Plan.

- B. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures.
- C. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides EPHI, agrees to implement reasonable and appropriate security measures to protect such information.
- D. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - 1. Plan Sponsor shall report to Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of Plan's EPHI; and
 - 2. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.