



*In alliance with
The University of Vermont*

Fletcher Allen Preferred Medical Plan

Summary Plan Document

Effective January 1, 2002

Revised January 2006

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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 comprehensive coverage. These benefits can help you get the treatment you need and want for your own and your family's health.

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

This booklet is a summary plan description of your Fletcher Allen Preferred Medical Plan medical care benefits; it also serves as the full Plan Document. It does not contain all details of Medical Policy that guide Utilization Review decisions. These are available upon request from Vermont Managed Care.

This booklet is neither a contract of current or future employment, nor does it guarantee payment of benefits.

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

Benefits described in this document are effective January 1, 2002 and revised January 1, 2006. Technical terms are capitalized and defined in the Definitions section.

MEDICAL PLAN HIGHLIGHTS

This is a summary of your Fletcher Allen Preferred Medical Plan benefits. You receive these benefits only when you use the Participating Providers in the Vermont Managed Care Network, pharmacies participating in the CIGNA Healthcare Prescription Drug Program, and behavioral health providers participating in the CIGNA Behavioral Health network. **No benefits are paid when you use non-participating providers, except where Emergency Services are required or where you have received written Pre-Approval.**

This is an open access plan. Primary Care Physician referrals are not required. However, necessary Pre-Approval is required for inpatient and intensive outpatient behavioral health services and certain medical procedures and treatment (see Pre-Approval section on pages 19-20).

Fletcher Allen Preferred Medical Plan* <i>(Open Access-No Primary Care Physician Referrals Required)</i>	
Benefits/Services	In-Network Coverage
Lifetime Maximum	Unlimited
Annual Deductible (Individual/Family)	Not Applicable
Annual Out-of-Pocket Maximum (Individual/Family)	\$1,000/\$3,000 Includes coinsurance only.
Pre-Existing Condition Limitation	N/A
<u>Office Visits</u>	
<ul style="list-style-type: none"> • Co-payment Primary Care • Co-payment Specialists • Coinsurance (you pay/Plan pays) 	\$10 \$25 N/A
<u>Preventive Care</u>	
<ul style="list-style-type: none"> • Co-payment for Primary Care • Coinsurance (you pay/Plan pays) 	\$10 N/A

Benefits/Services	In-Network Coverage
<p><u>Maternity</u></p> <ul style="list-style-type: none"> • Co-payment for Office visit to Confirm Pregnancy • Co-payment for Prenatal/Postnatal Visits • Co-payment for other Specialist visits • Coinsurance (you pay/Plan pays) 	<p>\$10 N/A \$25 N/A</p>
<p><u>Inpatient Hospital</u></p> <ul style="list-style-type: none"> • Co-payment • Coinsurance (you pay/Plan pays) 	<p>\$250** per admission N/A</p>
<p><u>Outpatient Surgery</u></p> <ul style="list-style-type: none"> • Coinsurance (you pay/Plan pays) • Office Surgery Co-payment • Office Surgery Coinsurance (you pay/Plan pays) • Coinsurance for Surgeon Fees (you pay/Plan pays) • Second Opinion Co-payment • Second Opinion Coinsurance (you pay/Plan pays) 	<p>10%/90% \$25 N/A 10%/90% \$25 N/A</p>
<p><u>Other Outpatient Services</u></p> <ul style="list-style-type: none"> • CT Scans/MRI/Nuclear Scans Co-payment • Coinsurance (you pay/Plan pays) • Other Major Diagnostics Co Payment • Coinsurance (you pay/Plan pays) 	<p>N/A 10%/90% N/A 10%/90%</p>
<p><u>X-ray and Laboratory Services (Diagnostic)</u></p> <ul style="list-style-type: none"> • Coinsurance (you pay/Plan pays) 	<p>10%/90%</p>
<p><u>Emergency Services</u></p> <ul style="list-style-type: none"> • Co-payment for Emergency Room • Coinsurance for Ambulance – Emergency (you pay/Plan pays); • Non-emergent Ambulance 	<p>\$50 (waived if admitted) N/A Not covered</p>
<p><u>Urgent Care Center or Walk-In Care Center</u></p> <p>Co-payment</p>	<p>\$25</p>
<p><u>Rx Drug Retail Co-payments (30 Day Supply)</u></p> <ul style="list-style-type: none"> • Retail Generic • Retail Preferred Brand • Retail Non-Preferred Brand 	<p>\$10 \$20 \$35</p>

Benefits/Services	In-Network Coverage
<p><u>Rx Drug Mail Order Co-payments (90 Day Supply)</u></p> <ul style="list-style-type: none"> • Mail Order Generic • Mail Order Preferred Brand • Mail Order Non-Preferred Brand 	<p>\$20 \$40 \$70</p>
<p><u>Mental Health/Substance Abuse Inpatient</u></p> <ul style="list-style-type: none"> • Co-payment • Coinsurance (you pay/Plan pays) <p><u>Residential and Partial Hospital-Counted as 2 partial days to 1 inpatient day</u></p> <p><u>Annual Calendar Year Limit</u></p>	<p>\$250** N/A</p> <p>None</p>
<p><u>Mental Health/Substance Abuse Outpatient/Individual Therapy</u></p> <ul style="list-style-type: none"> • Co-payment • Coinsurance (you pay/Plan pays) <p><u>Group Therapy</u></p> <ul style="list-style-type: none"> • <u>Co-payment</u> • <u>Coinsurance</u> <p><u>Intensive Outpatient Treatment Programs</u></p> <ul style="list-style-type: none"> • Co-payment • Coinsurance <p><u>Annual Calendar Year Limit</u></p>	<p>\$25 N/A</p> <p>\$10 N/A</p> <p>\$10 N/A</p> <p>None</p>
<p><u>Infertility</u></p> <ul style="list-style-type: none"> • Office Visit Co-payment (for evaluation and testing only) • Office Visit Coinsurance (you pay/Plan pays) • Surgery Coinsurance (you pay/Plan pays) 	<p>\$25 N/A 10%/90%</p>
<p><u>Outpatient Rehabilitation (Physical, Speech, and Occupational Therapies for short term, acute care)</u></p> <ul style="list-style-type: none"> • Co-payment-FAHC Provider • Co-payment –Non FAHC Provider • Coinsurance (you pay/Plan pays) • Combined Maximum Annual Benefit Allowed Under Plan 	<p>\$10 \$25 N/A 30 visits</p>

Medical Plan Highlights

Benefits/Services	In-Network Coverage
<u>Special Services</u>	
<i>Skilled Nursing Facility</i> <ul style="list-style-type: none"> • Co-payment • Coinsurance (you pay/Plan pays) • Maximum Annual Benefit Allowed Under Plan 	\$250** N/A 120 days
<i>Home Health Care</i> <ul style="list-style-type: none"> • Co-payment • Coinsurance (you pay/Plan pays) 	N/A 10%/90%
<i>Hospice</i> <ul style="list-style-type: none"> • Co-payment • Inpatient Coinsurance (you pay/Plan pays) • Outpatient Coinsurance (you pay/Plan pays) 	N/A N/A N/A
<u>Chiropractic Care</u>	
<ul style="list-style-type: none"> • Co-payment • Coinsurance (you pay/Plan pays) • Maximum Annual Benefit Allowed Under Plan (includes your \$25 co-payment) 	\$25 N/A 12 visits \$40 per visit maximum benefit
<u>Routine Vision Exam</u>	
<ul style="list-style-type: none"> • Co-payment • Coinsurance (you pay/Plan pays) • Maximum Benefit Allowed Under Plan 	\$15 N/A 1 visit every 24 months
<u>Non-surgical TMJ Treatment</u>	
<ul style="list-style-type: none"> • Co-payment • Coinsurance (you pay/Plan pays) • Maximum Annual Benefit Allowed Under Plan 	\$25 N/A \$1,000
<u>Durable Medical Equipment</u>	
<ul style="list-style-type: none"> • Co-payment • Coinsurance (you pay/Plan pays) 	N/A 20%/80%

- *See “Services Not Covered” on pages 34 – 39
- **Limited to 4 Co-payments per person, per year. The 5th and subsequent admissions have no co-payment.

NOTE: Coverage is based on the allowable amount, which is the Reasonable and Customary determined by the Plan charge for the services provided. If you receive services from a non-Participating Provider-even if they are pre-approved- you may be responsible for charges above the Reasonable and Customary charge.

WHO IS ELIGIBLE

Fletcher Allen offers medical coverage to all full-time and part-time Employees regularly scheduled to work at least 40 hours per pay period. Medical coverage under the Plan, however, is not available to Employees classified as Per Diem (including hourly, on-call, non-benefit-eligible employees) and Regularly Scheduled Special (RSS) employees.

Members of your family may also be eligible for coverage. Eligible family members include:

- ◆ Your spouse or your partner under a Vermont Civil Union.
- ◆ Your unmarried natural, legally adopted (including a child placed for adoption during the waiting period before adoption becomes final) 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 Employee), and are dependent on you (the Employee) 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 dependant 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 is dependent on you for support, and whose handicap began before age 19. A child is considered handicapped if she/he is a child who is incapable of self-support due to mental or physical illness or injury. A Physician must certify the physical or mental handicap including the incapability of self-support. The Plan may require a Physician's 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.

If you have reached your normal retirement date and are still actively employed, in a benefit-eligible status, you will be covered by this Plan for the

same benefits as would apply for a person under age 65 who is not eligible for Medicare. See pages 42 - 43 for further explanation on “Coordination of Benefits” under Medicare.

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: *Employees who are eligible for benefits under this Plan and who are married to, (or are a civil union partner of, another eligible Fletcher Allen Employee may not be covered as an Employee and family member under Fletcher Allen health plans at the same time. If more than one family member is eligible for medical benefits under this Plan, , the family member must elect either single coverage as the eligible employee, or be listed as a dependent under the other eligible employee’s (spouse’s) Plan.*

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 to reduce or eliminate any pre-existing 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 Plan when one of the following apply:

- ◆ 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 termination of employment, 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

- ◆ On your request, within 24 months after your Plan coverage ends

Call Vermont Managed Care at (802) 847-4862 to request a HIPAA Certificate
of Creditable Coverage.

WHEN COVERAGE BEGINS

You and your eligible dependents are eligible for coverage on the first of the month following your date of hire. If your hire date is coincident with the first day of any month, your coverage will become effective that day. You must enroll in the Plan before coverage can begin. Enrollment forms are available from the Human Resources Department.

Eligible employees and their dependents must enroll within thirty-one (31) days of the date the employee or family member becomes eligible for the Plan; otherwise they are not eligible to enroll in the Plan until the next open enrollment period.

Spouses 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. Newborn children of dependents are not eligible for coverage under this plan. Adopted, foster or step-children must be enrolled within thirty-one (31) days of adoption date or placement for adoption or relevant court order date.

Important Note: You must complete the proper forms to enroll any new dependents including newborn children within 31 days of birth. Contact the Human Resources Benefits Department at (802) 847-2825, option #2 to obtain these forms. If you do not enroll your eligible dependents within the 31-day period, your child will not be eligible for coverage until the next open enrollment period.

An exception to the rule that postpones enrollment until the next open enrollment period will be made if you elect not to pay the premium at the beginning of your eligibility period because you or your family members had

coverage under another plan, but you (or your family members) then lose that coverage because employer contributions cease or because of a loss of eligibility resulting from a change in family status (i.e., legal separation, divorce, termination of employment, reduction in hours, exhaustion of COBRA, children's aging out of coverage, or moving out of an HMO service area) other than a failure to pay participant premiums or termination of coverage for cause (such as fraud). In that event, you will be given the opportunity to purchase coverage for them and yourself provided that you notify the Plan in writing within thirty-one (31) days of the qualifying event. If the other coverage was COBRA coverage, this exception only applies after the COBRA coverage is exhausted. Finally, an exception may also be made if you acquire a new family through marriage, birth, adoption, or the placement of a child for adoption. In that event, you may add the new family member to coverage by providing written notice to the Plan within thirty-one (31) days of the marriage, birth, adoption or placement for adoption. Coverage for you or your family members confined to a Hospital or Skilled Nursing Facility on the day coverage would otherwise become effective when any prior medical coverage ends.

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 calendar year. You will then have the opportunity during the annual open enrollment period to decide what level of coverage you want for yourself and your dependents for the coming year.

Once you select the level of coverage for a Plan Year, you generally may not change that coverage during the Plan Year unless you experience a qualified change in your family or employment status. By law, family status changes must be reported within thirty-one (31) days of the event and include (but are not limited to):

- ◆ Marriage or divorce
- ◆ Birth, change in custody or adoption (including placement for adoption of a child), placement of foster child or step-children.
- ◆ Changes in your spouse's employment
- ◆ Death or disability of you or a family member covered under the Plan
- ◆ Change in employment status (for example, termination or commencement of employment, or switching from full-time to part-time, or vice versa by you or your spouse)
- ◆ Taking an approved unpaid leave of absence by you or your spouse
- ◆ 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

In the absence of a "qualifying event" as described above, you are not permitted to change your coverage election during the year, but rather, only during the next annual open enrollment period.

HOW MEDICAL COVERAGE WORKS

If you obtain services from a Network Provider, this is how medical coverage works:

- ◆ First you pay --

a co-payment for most services
(see Medical Plan Highlights on pages 2-5)

- ◆ After the co-payment (if required), the Plan pays--

100% of covered services not requiring co-insurance, 80-90% of services requiring co-insurance.

- ◆ If Coinsurance is required --

You share the cost with the Plan.
(see Medical Plan Highlights on pages 2-5)

- ◆ When your share of expenses reaches your out-of-pocket maximum-

the Plan pays 100% of the rest of your covered services,
(excluding co-payments other than those for fifth or more inpatient admissions, deductibles or Plan maximums)
for the remainder of the Plan Year

If you obtain medical services from a non-Network Provider, you will not be covered under this plan, except for Emergency Services or where Vermont Managed Care provides written Pre-Approval.

NOTE: Coverage is based on the allowed amount, which is the Reasonable and Customary determined by the Plan charge for the services provided. If you receive services from a non-Network Provider-even if they are pre-approved- you may be responsible for charges above the Reasonable and Customary charge.

Your Co-payments

You are responsible to pay to the provider a co-payment for most covered medical services before the Plan pays benefits. Co-payments range from \$10 to \$250 depending on the type of service and who provides it. Co-payment amounts are specified in the Medical Plan Highlights on pages 2 - 5.

Coinsurance

Coinsurance means that both you and Fletcher Allen Health Care share the cost for medical services rendered. For example, you are responsible for paying 10% of the cost of diagnostic imaging, laboratory, and outpatient surgery, home health services, and 20% of the cost of all Durable Medical Equipment items. See the Medical Plan Highlights on pages 2 - 5 for a complete listing of your coinsurance obligations.

Out-of-Pocket Maximum

After you pay a your portion of Coinsurance for certain covered services for you or for your family members, you pay nothing more than the required co-payment for these covered services for the rest of the Plan Year, but only if you (or your family members) use Network Providers (except for Emergency Services and Pre-Approved Out of Network services for which the applicable Plan procedures have been followed). The Plan pays 100% of the allowed amount for all remaining expenses for the remainder of the Plan Year. The annual out-of-pocket coinsurance maximum you must pay is \$1,000 for you or \$3,000 for you and your family members using Network Providers.

Covered services for which the out-of-pocket coinsurance maximum applies include but are not limited to: diagnostic imaging, laboratory, outpatient surgery, durable medical equipment and home health services. Co-payments for doctor's office visits, hospitalization, emergency room, and prescription drugs do not apply to the out-of-pocket maximum. Charges exceeding the annual Benefit Maximum do not apply to the Out-of-Pocket maximum.

Lifetime and Annual Benefit Maximums

The maximum benefit you or any of your covered family members can receive during a year or lifetime is not limited. However, some specific areas of coverage are limited as follows:

- ◆ Chiropractic care is limited to 12 visits with a \$25 co-pay per calendar year (\$15 maximum Plan payment).
- ◆ Skilled Nursing Facility coverage is limited to 120 days per calendar year.
- ◆ Speech, occupational and physical therapy is limited to 30 combined visits per calendar year.
- ◆ TMJ treatment is limited to \$1,000 per Plan Year (excluding PT and surgical services. Oral appliances and splints are covered as Durable Medical Equipment).
- ◆ Routine vision coverage is limited to one visit every 24 months.
- ◆ Nutritional counseling is limited to a maximum of 3 visits per diagnosis per lifetime.
- ◆ Medical Foods for inherited metabolic disorders are limited to a maximum of \$2,500 per year. Pre-approval is required.

Medically Necessary

For benefits to apply under the Plan, items or services rendered 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. See “Pre-Approval” section of this booklet for more information on pages 19 - 20.

Covered Services

Certain expenses are covered by the Plan, others are not. A detailed but not all-inclusive list of covered services can be found in the “Covered Services” section of this booklet on pages 25-31. A detailed but not all-inclusive list of services not covered by the Plan can be found under the “Services Not Covered” section of this booklet on pages 34-39. Please call Vermont Managed Care at (802) 847-4862 or toll free at (866) 582-6836 for specific questions regarding your coverage.

USING YOUR COVERAGE

When you enroll, you may access a directory of the Network Providers in your area on the Fletcher Allen Preferred web site (www.fahcpreferred.org). This directory includes Participating Medical Provider addresses, telephone numbers and specialties. It also includes links to websites of Vermont Managed Care, CIGNA Behavioral Health and CIGNA Prescription Drug Program. Paper directories are available, without charge, by calling the number on the back of your ID card (802) 847-4862 or toll free at 1-866-582-6836. You must enroll with a Primary Care Physician in the Network, but may use any Participating Provider listed in the directory. Generally you must use a Network Provider to be covered at the maximum benefit level under the Plan. Benefits are paid only for Medically Necessary services from these participating providers except where out of network Emergency Services are used or when written Pre-Approval is obtained. Make sure that you show your membership card when you visit the Participating Provider.

Note: Your medical Plan Identification Number is your Fletcher Allen employee number preceded by “FA”. If you do not know your employee number, you may call Human Resources for assistance.

Access and referral to the CIGNA Behavioral Health network of Mental Health and Substance Abuse Treatment Providers is available to you on the CIGNA Behavioral Health website: www.cignabehavioral.com or by calling (800) 554-6931.

In cases where Emergency Services are required, you may need to use a non-Participating Provider. In these cases, benefits will be paid as if you had used a Participating Provider as described in this booklet. For Medical Hospital admissions/Emergency Services, you (or a member of your family or your medical services provider) must notify Vermont Managed Care of your

admission to a non-Participating Provider within 48 hours to receive coverage under the Plan. Vermont Managed Care may be contacted at (802) 847-4862 or toll free at (866) 582-6836.

Pre-authorization for Mental Health and Substance Abuse Treatments is required for all inpatient, residential, partial hospital and intensive outpatient care programs. In cases where Emergency Services are required for mental health or substance abuse treatment, notification must be received within 24 hours. CIGNA Behavioral Health may be contacted at (800) 554-6931.

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. The Pre-Approval program is managed by Vermont Managed Care for medical services, CIGNA Behavioral Health for mental health and substance abuse services, and CIGNA Prescription Drug Program for prescription drugs. ***Please refer to the “Pre-Approval and Concurrent Review” section of this booklet (see pages 21-24) for a list of procedures that require Pre-Approval under the Plan. Failure to comply with the Plan’s Pre-Approval requirements may result in denial of coverage under the Plan.***

Your Physician should complete the Pre-Approval process as soon as possible, but generally no later than 5 working days before you receive one of the services listed in the “Pre-Approval and Concurrent Review” section of this booklet or before a Hospital admission. To assure timely notification to Vermont Managed Care, you may contact Vermont Managed Care at (802) 847-4862 or toll free at (866) 582-6836. You are responsible for making sure that your Physician submits the request. You, your Physician and the Hospital will be notified of the Pre-Approval decision within 15 days after receipt of the request. In special circumstances, a response to your request for Pre-Approval may take more than 15 days. If an extension is needed, you will receive written notice before the end of the 15-day period. In no event will the extension be more than 15 days.

Pre-Approval for Urgent Medical Care Claims

For Pre-Approval requests for Claims Involving Urgent Care, Vermont Managed Care will notify you and your Physician of the Pre-Approval decision within 24 hours of receipt of the request for services. If Vermont Managed Care

Pre-Approval Program

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 or treatment is not approved, you or your Physician may appeal the decision. See the “Appeals Policy” section of this booklet on pages 71-80 for instructions on the appeals process.

Pre-Approval for Urgent Mental Health and Substance Abuse Treatment

Claims

All inpatient, partial hospital and intensive outpatient mental health services and drug or alcohol abuse treatment must be Pre-Approved by CIGNA Behavioral Health at (800) 554-6931 prior to receiving services. CIGNA Behavior Health must be notified of Emergency Services care or admissions for mental health or substance abuse within 24 hours of the admission.

PRE-APPROVAL & CONCURRENT REVIEW

The Plan pays benefits for certain services only if you and your Physician follow the pre-approval and concurrent (ongoing) review program procedures. Failure to comply with these procedures may result in denial of benefit coverage under the Plan.

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 by Registered Nurse case managers to ensure that medical resources are efficiently used. Pre-Approval and ongoing reviews are handled by Vermont Managed Care, Care Management Department.

If your Physician recommends that you or a family member be hospitalized, you or your Physician must call Vermont Managed Care for Pre-Approval.

***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***

Vermont Managed Care's telephone number is printed on the back of your Medical Plan 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 the cost of any services not paid for by the Plan.

The concurrent review program nurses will conduct ongoing reviews with your Physician throughout your Hospital stay. The Plan pays regular benefits only for

the length of stay approved by Vermont Managed Care. Benefits for non-approved Hospital stays may be reduced or denied.

Mental Health and Substance Abuse Inpatient Pre-Approval and Concurrent Review

Pre-Approval is required for inpatient, partial hospitalization, residential and intensive outpatient care. In the case of an emergency admission at an in-network facility or program, notification must be received within 24 hours of the admission to be covered at in-network benefit levels. In the case of an emergency admission at an out of network facility, notification must be received within 24 hours of the admission to ensure coverage.

***Inpatient, Partial Hospital and Intensive Outpatient Treatment for Mental Health and Alcohol or Drug Abuse
must be Pre-approved through CIGNA Behavioral Healthcare (CBH)
by calling (800) 554-6931 24 hours a day, 7 days a week***

Outpatient Procedures Requiring Pre-Approval by Vermont Managed Care

The list below includes diagnostic and therapeutic procedures which are sometimes done on an outpatient basis. When done on an outpatient basis, these procedures require authorization by Vermont Managed Care's Care Management department. Call to request Pre-Approval at least 5 or more days before a planned elective procedure if possible. Call within 48 hours after an emergency procedure or on the morning of the next business day after a holiday or weekend emergency procedure or admission.

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

- ◆ Physician's address and phone number
- ◆ Diagnosis and/or procedure planned (see table on following page)
- ◆ Patient's address, phone number, member ID number, and birth date
- ◆ Employee's address, phone number and member ID number
- ◆ Employee's name

- ◆ Name, phone number and address of the Hospital or outpatient procedure center
- ◆ Planned date of service

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.

PROCEDURES REQUIRING PRE-APPROVAL	
General:	Drug Therapy:
All Cosmetic or Reconstructive procedures (includes skin lesions)	Amevive
All inpatient admissions	Botulinum Toxin Treatment
All requests for out-of-network services	Folan
All Home Health/Hospice Care	Gamma Globulin for polyneuropathy
Medical:	Gaucher's disease treatment
Air medical transport	GnRH, Lupron, Zolodex
Cardiac Rehabilitation	Growth Hormone
Continuous positive airway pressure testing	Hemophila factor
Dialysis (renal or peritoneal)	Hepatitis B vaccine (over age 18)
Enteral therapy	Interleuken-2
Genetic counseling and testing	Lymerix vaccine
Hyperbaric O ₂ (HBO)	
Pain Management Programs	Mitoxantrone forms
Psoriasis treatment/PUVA Lights	Peg Intron
Pulmonary rehabilitation	Pevnar (over 24 mos. of age)
Surgical:	Remicade
Autologous chondrocyte implantation	Synagis
Breast augmentation/reduction surgery	Durable Medical Equipment (DME) – all DME with cost greater than \$500, including but not limited to:
Breast Surgery in males	
Dermabrasion	
**Diagnostic Laparoscopy	
** Hysterectomy	Continuous Passive Motion Devices
Laser treatments: example:, port wine stains/ rosacea	CPAP/BiPAP
** Lumbar Laminectomy (Discectomy)	Dorsal column stimulator
Organ/Stem Cell/Bone marrow transplant	Electrical bone stimulator
Orthognathic surgery	Electric Wheelchair/scooters
Rhinoplasty	Emerson in-sufflator
Sclerotherapy	Erectile dysfunction devices
** Septoplasty	Foot orthotics
** Sinus Surgery/FESS Procedure	Insulin pump and supplies
** Spinal Fusion	Light therapy for seasonal affective disorder
Uterine artery embolization	Lymphedema pumps
Uvulopalatopharyngoplasty (UPPP)	Orthotic devices (braces)
Varicose Vein Surgery	Pressure garments
Diagnostic Testing:	Prosthetic devices, external
** CT Scans, MRIs, Myelograms (Cervical, Lumbar, Sacral), Cardiac MRI, MRI of Breast	Sacral nerve stimulator for urinary incontinence
PET Scans, MRS	ThAIRapy vest
Skin endpoint titration	Vitajet injector
	Wheelchairs

Video EEG monitoring	Cranial Prosthetics (wigs)
Ancillary:	
Speech Therapy	

** Participating Provider financially liable for failure to obtain Pre-Approval. All others, patient financially liable for non-covered balances.

NOTE: All injectable medications purchased through a retail pharmacy under the CIGNA Healthcare Prescription Drug Program benefit require Pre-Approval by calling (800) 622-5579.

COVERED SERVICES

The term “covered services” means the services received by an active Plan Participant or their covered eligible dependents 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 are provided by a Network Provider or by a non-Network Provider for Emergency Services, (or where Pre-Approval is obtained), and are Medically Necessary. The following list includes most, but not all, of the services and supplies covered by the Plan:

- 1) **Ambulance** emergency ground 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 unless otherwise approved by VMC.
 - ◆ Between facilities, when Medically Necessary and pre-approved
 - ◆ Air medical transport must be pre-approved.

- 2) **Chiropractic Care**

Charges made by a licensed chiropractor for professional services - limited to 12 visits per year. Includes x-rays and service diagnostics performed by the chiropractor.

- 3) **Diabetic Supplies**
 - ◆ Diabetic insulin pumps are a covered benefit and are reimbursed as Durable Medical Equipment at 80% of Usual and Customary Charge. Pump Supplies are covered at 100% of Usual and Customary Charge.
 - ◆ Other diabetic supplies are not covered by the medical plan but may be covered through the prescription drug plan.

- 4) **Durable Medical Equipment (DME)**

DME which is Medically Necessary for the care of a Sickness or Injury is covered. DME may be rented or purchased. Pre-Approval is necessary for any items with a purchase price of \$500 or more, or **any** rental equipment and external prosthetics.

 - ◆ 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
 - 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 (coverage for these items may be approved for diabetics. Pre-approval is required)
 - blood pressure machines or cuffs.
 - heating pads, hot water bottles, disposable items (e.g. 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
 - stair chairs
 - physical fitness, gym memberships, exercise equipment including isometric, isotonic and isometric devices, and ultraviolet/tanning equipment
 - home modifications. For example: lifts, chair glides, “barrier-free” construction
 - breast pumps (consideration may be given with pre-approval for the rental of a breast pump for mothers with pre-term or other neonates requiring intensive care hospitalization.)
- ◆ Pressure Garments, such as compression hose may be covered with clinical documentation of lymphedema or functionally limiting varicose veins. Requires pre-approval.

5) **Emergency Services**

Emergency Services are covered at a Network Provider facility to the extent that they are Medically Necessary [subject to the judgment of a prudent layperson]. Emergency Services are subject to co-payments. However, co-payments are waived if an acute inpatient admission results. Plan authorization for such service must be obtained within 48 hours after the service. **Note:** For all mental health and substance abuse emergencies, notification should be received within 24 hours of the admission. No co-

payments are required for outpatient Emergency Hospital services out of the Network. 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.

- 6) **Genetic Counseling/Testing** - requires Pre-Approval for medical necessity.

- 7) **Home Health Care** - requires Pre-Approval

The Plan will provide benefits as detailed in the Medical Plan Highlights (pages 2-5) for home health care charges made by a Home Health Care Agency for the following 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 Registered 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 (inclusive of 30 visit limit); 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.

- 8) **Hospice Care** - requires Pre-Approval

- ◆ 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/IM/SC therapies for hydration, pain management and/or antibiotics
- epidural pain control
- continuous care nursing services
- respite, homemaker services, custodial services

9) **Infertility**

- ◆ For diagnostic testing and evaluation leading to the diagnosis of infertility

Medically Necessary surgical corrective procedures (requires Pre-Approval)

10) **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 must 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 pre-maturity. 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 beyond the 31 day period, you must enroll the child for coverage within 31 days of birth. Otherwise, your child will have no coverage after the initial 31 day period.**

Maternity care requires a \$10 co-pay to confirm pregnancy. No further co-payment is required for routine maternity care in the office setting. However, if you should require specialty care services, for example, an

amniocentesis, or referral to high-risk maternal-fetal medicine physicians, a specialty care co-payment of \$25 per visit may be necessary. In some cases, you will also pay 10% of any diagnostic testing, X-ray or laboratory fees.

****VMC offers a Maternity Wellness Program. This program offers added benefits for expectant parents who voluntarily enroll in the program. For more information contact VMC at 802-847-8161 or 1-866-582-6836.***

11) **Medical Hospital Inpatient Care**

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

12) **Medical Hospital Outpatient Care**

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

13) **Mental Health and Substance Abuse Treatments** - Inpatient, partial hospitalization, residential and intensive outpatient care requires Pre-Approval; to obtain Pre-Approval, call CIGNA Behavioral Health at (800) 554-6931.

14) **Nutritional Counseling**

Limited to 3 visits per diagnosis per lifetime.

15) **Office Visits**

- ◆ Professional service provided in an office setting including preventive care, immunizations, injections, pre- and post- natal care and periodic health evaluations
- ◆ Consulting Physicians, second opinions

16) **Pain Management Program** - requires Pre-Approval

17) **Prostheses/Prosthetic Medical Appliance**

- ◆ External:
 - which are used as a replacement or substitute for a missing body part and are necessary to alleviate or correct sickness, injury or congenital defect; limited to:
 - artificial upper and lower extremities
 - ocular prosthesis

- breasts
- wigs for chemotherapy induced alopecia (pre-approval required), subject to limitations on medical plan highlights under Durable Medical Equipment (see page 5).

18) **Rehabilitation Services**

- ◆ **Inpatient:** - requires Pre-Approval
 - for all services provided by a licensed acute or sub-acute rehabilitation facility
- ◆ **Outpatient:**
 - for services of physical therapy, occupational therapy, and speech therapy; limited to 30 combined visits per year, inclusive of all outpatient therapies that are acute in nature and medically necessary.

19) **Skilled Nursing Facilities (SNF)** - requires Pre-Approval

- ◆ **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 year

20) **Transplant Services** - requires Pre-Approval

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

21) **Vision Care**

Maximum benefit is 1 visit every 24 months for routine vision care including refraction.

22) **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 co-insurance applicable to other medical and surgical benefits provided under this Plan. Therefore, the following deductibles and coinsurance apply: \$10 co-payment for Primary Care, \$25 co-payment for Specialist Care, \$250 Co-payment for Inpatient Hospital Care, 10% Coinsurance for outpatient Surgical Care. Refer to the Medical Plan Highlights on pages 2-5 for more complete information on deductibles and Coinsurance.

If you would like more information on WHCRA benefits, call the Plan Administrator, Vermont Managed Care, toll-free at 1-866-582-6836 or (802)847-4862.

PRESCRIPTION DRUGS

The Plan covers FDA approved prescription drugs and medicines, prescribed by a Physician and dispensed by a licensed pharmacist and (if you have enrolled in a plan that covers services only if they are provided by Network Providers) are purchased at a participating pharmacy.

Covered Drugs

The following items are covered under the Plan:

- ◆ Federal legend drugs (that is, drugs that federal law prohibits dispensing without a prescription) except as excluded below
- ◆ Compound prescriptions containing at least one legend ingredient
- ◆ Insulin
- ◆ Disposable insulin syringes/needles
- ◆ Oral contraceptives/Norplant implant

Drugs Not Covered

The following items are not covered under the Plan:

- ◆ Weight reduction drugs
- ◆ Devices and appliances
- ◆ Fertility drugs
- ◆ Over-the-counter items
- ◆ Retin-A (for anyone over age 36)
- ◆ Rogaine (or similar products)
- ◆ Viagra (exception: organic or disease/surgery induced impotence covered when Pre-Approval is obtained)

Brand vs. Generic Drugs

Drugs have two names: a trademark or “brand” name, and a chemical or “generic” name. Many brand-name prescriptions have a less expensive “generic equivalent” available. Ask your Physician to prescribe generic drugs whenever possible.

By law, brand name and generic drugs must meet the same standards for safety, purity, strength and quality.

Your Cost

When you have your prescriptions filled at a retail or mail service pharmacy, you pay a co-payment; the Plan pays the rest.

Your co-payments for prescriptions under the Plan are as follows:

- ◆ Up to a 30-day supply obtained through participating retail pharmacy:
 - Generic: \$10
 - Preferred Brand: \$20
 - Non-Preferred Brand: \$35

- ◆ Up to a 90-day supply obtained through participating mail service pharmacy:
 - Generic: \$20
 - Preferred Brand: \$40
 - Non-Preferred Brand: \$70

NOTE: *Your prescription will be filled for the exact amount prescribed by your Physician, up to the 30 or 90-day supply limit.*

SERVICES NOT COVERED

Certain expenses are not covered by the Plan and, therefore, are not eligible for payment under the Plan. The following list includes most, but not all, of the services and supplies not covered by the Plan.

- 1) **Alternative or Complementary Therapeutic Practices** including, but not limited to, acupuncture, acupressure, aromatherapy, naturopathy, massage therapy, hypnotherapy, homeopathy, rolfing, Reiki, self-help training, and other therapies not specifically listed as covered.
- 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) **Behavioral Health Exclusions:**
 - Organic Mental Disorders
 - Mental Retardation and Autism
 - Developmental and learning disabilities
- 5) **Charges in excess of Reasonable and Customary Charges**
- 6) **Charges submitted by a Provider who is rendering care to himself/herself or his/her family member.**
- 7) **Charges which the Participant is not legally required to pay.**
- 8) **Charges which would not have been made if the Participant had no insurance.**
- 9) **Charges for any item or service not elsewhere listed in this document as a covered benefit.**
- 10) **Chronic care**
- 11) **Circumcision**
 - ◆ **Exception:**
 - if Medically Necessary, subject to Pre-Approval

- 12) **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, subject to Pre-Approval
 - reconstructive surgery following a mastectomy related to breast cancer, including surgery and reconstruction of the unaffected breast, for the purpose of achieving symmetry or as otherwise required by federal law. Subject to pre-approval.
- 13) **Costs** related to your failure to keep appointments with providers.
- 14) **Court Ordered Treatment/Services:** forensic evaluations or court ordered service.
- 15) **Custodial Care and Personal Comfort Items,** including but not limited to personal care kits, television and telephone rentals.
- 16) **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 caries, 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). Injury must have been sustained while eligible for coverage under this plan or another plan subject to HIPAA as outlined on page 8-9 of this booklet but not greater than 2 years prior to seeking treatment.
- 17) **Disposable Medical Supplies** Including but not limited to medical clothing to block UVA/UVB sun rays, dressing supplies, over-the-counter splints, air casts, corsets, shoe insert orthotics, braces, elastic wraps such as ACE bandages, sanitary items.

- ◆ Exception:
 - ostomy supplies
 - diabetic supplies required for insulin pump therapy

- 18) **Employment-Related Injury or Sickness** which is covered or eligible for coverage under any workers' compensation or similar law including work hardening programs.

- 19) **Experimental or Investigational** treatments, procedures, devices or prescriptions.
 - ◆ Exception:
 - new technology when written pre-approval is obtained by the Participant from the VMC Medical Director

- 20) **Foot Care; Routine** in connection with corns, calluses, nail care.
 - ◆ Exception:
 - diabetic foot care

- 21) **Hearing Exams and Hearing Aids** and their fitting or hearing device implants.
 - ◆ Exception:
 - initial hearing screen as part of preventive evaluation and management
 - audiology exam.

- 22) **Home Birth** charges in connection with home birthing services. Any charges associated with pre-natal care, birthing services or post natal care provided by or submitted for payment by non licensed providers, such as a lay midwife.

- 23) **Infertility**

Artificial insemination, in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) or any services connected with the above.

- 24) **Medical Foods**

Infant formulas, over-the-counter nutritional supplements.

 - ◆ Exception:
 - enteral feedings requiring a physician prescription
 - Medical Foods for inherited metabolic disorders up to a maximum of \$2,500 per year. Subject to pre-approval.

- 25) **Non-Medically Necessary Services**
- 26) **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.
- 27) **Orthotics**
- ◆ **Exception:**
 - Medically Necessary ankle/foot orthotics (AFO). Subject to pre-approval.
 - Diabetics with clinical documentation of pressure areas and /or ulcers of the feet. Subject to pre-approval
- 28) **Outpatient Services** provided in a facility, which are routinely provided in an office setting. Outpatient surgery performed in a non-network facility located in Addison, Chittenden, Franklin, Grand Isle, Lamoille or Washington counties.
- 29) **Over-the-Counter, Disposable or Consumable Supplies or Convenience Items**, including but not limited to AC/DC converters for CPAP, home blood pressure monitoring devices.
- 30) **Physical Examinations** not required for health reasons; including, but not limited to employment, insurance, government license, court-ordered, forensic, driver or pilot's license, school, athletics, and travel.
- Exception:**
- ◆ Physician office visits for recommendations for vaccines required for international travel. Vaccines are excluded.
- 31) **Private Duty Nursing Services**
- ◆ **Exception:**
 - unless deemed Medically Necessary by Participating Provider and Pre-Approved by the Plan
- 32) **Private Hospital Rooms**
- ◆ **Exception:**
 - when medical necessity is determined by the attending Physician
- 33) **Reversal of Tubal Ligation**

- 34) **Reversal of Vasectomy**
- 35) **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.
- 36) **Services paid or eligible for payment by local (e.g. school systems), State or Federal programs except as otherwise required by law.**
- 37) **Services or supplies provided by non-Participating Providers, except as otherwise permitted under this Plan (e.g., Emergency Services, Pre-Approved services)**
- 38) **Services or supplies that are non Medically Necessary, unless otherwise provided herein.**
- 39) **Smoking Cessation Programs**
♦ Exception:
- prescription medications covered under pharmacy benefit
- 40) **Support Therapies:** e.g. pastoral counseling (except in the case of hospice), assertiveness training, dream therapy, music or art therapy, and recreational therapy.
- 41) **Temporomandibular Joint Syndrome (TMJ)**
Non-surgical treatment, exceeding a total of \$1000 maximum per covered person per year.

Note: PT, splints, oral orthotics/appliances and surgical treatment do not accumulate against the annual \$1,000 maximum benefit.
- 42) **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, subject to Pre-Approval
- 43) **Transsexual Surgery and Related Services** including hormone therapy.
- 44) **Travel and Housing Expenses** for out-of-network services.
♦ Exception:

- Subject to Pre-Approval, reasonable travel and housing expenses to the facility may be covered, if out-of-network services associated with the travel have been pre-approved, for the Participant only and excludes coverage for travel expenses of family members

45) **Travel Immunizations**

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

47) **Vision Care Services**

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, 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, while covered by the Plan
- one routine eye examination every 24 months

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

49) **Wigs or Cranial Prosthesis**

◆ Exception:

- Chemotherapy-induced alopecia only. Requires Pre-Approval.

FILING CLAIMS

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

For some charges, such as those for prescription drugs or medical equipment or other charges billed to you directly, you will need to file a claim yourself. Payment 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
P.O. Box 3620
Akron, OH 44309-3620

Mental Health and Drug and Alcohol Abuse Services

- ◆ CIGNA Behavioral Health
P.O. Box 46270
Eden Prairie, MN 55344-6270

Prescription Drug Services

- ◆ CIGNA Healthcare Prescription Drug Program
P.O. Box 780
Hartford, CT 06142-0780

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 Preferred Medical Plan claim forms for VMC, CIGNA Behavioral Health and CIGNA Healthcare Prescription Drug Program 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, and explain the Plan's review procedures, 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 71-80 for information on how to appeal denied claims.

COORDINATION OF BENEFITS

In many families, especially if both spouses work, 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 both plans are not more than 100% of the allowable amount. This is the benefit plan maximum. 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 its benefits for covered services, subject to maximums allowed under the terms of such plan. The following sets forth the order of benefit determination for 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.

Annually, the Plan will request information from each subscriber for all covered dependents to determine if there is coverage by multiple Plans. You must complete the Coordination of Benefits (COB) questionnaire mailed to you requesting this information. If you do not respond to the COB questionnaire, your claims payments may be delayed or denied until such time as VMC receives your completed form.

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, including but not limited to services not covered because they are provided by a non-Participating Provider.*

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, Sickness or 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 you 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 you or your family member's loss.

By you 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 you 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 you 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 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:

- ◆ On the last day of the month of the date when your employment with Fletcher Allen ends for any reason;
- ◆ When you no longer qualify as an employee working 40 hours or more per pay period;
- ◆ If you fail to make the required contribution for medical coverage;
- ◆ When Fletcher Allen stops offering 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.

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 6 - 7 for the definition of eligible family member);
- ◆ If you fail to make the required contribution for family medical coverage;
- ◆ If Fletcher Allen stops offering family medical coverage.

IF YOU LEAVE FLETCHER ALLEN HEALTH CARE -
CONTINUATION OF COVERAGE-CONSOLIDATED OMNIBUS
RECONCILIATION ACT (COBRA)

In some cases, you or your covered 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...

Your employment ends for any reason
(other than gross misconduct)...

Your hours are reduced and you are no
longer a benefits eligible employee ...

You divorce or legally separate...

You die...

You become entitled to Medicare
benefits...

Your covered child no longer qualifies
for coverage...

You elect continuation of coverage due
to termination of employment, disability
or reduction in hours and you or a
covered family member qualify for
Social Security disability benefits at any
time during the first 60 days of
continuation coverage.

Then...

Coverage for you and/or your covered
family members can be continued for up
to 18 months

Coverage for you and/or your covered
family members can be continued for up
to 18 months

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 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 for the disabled person can be
continued for an additional 11 months to
a total of 29 months.

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. If you or your family members are disabled (as determined under the Social Security Act) at the time of termination or reduction in hours or become disabled at any time during the first 60 days of continuation coverage, you or your family member must notify Fletcher Allen within the original 18-month continuation coverage period and within 60 days after you or your family member receive notification of determination of disability in order for continuation coverage to be extended to 29 months for the disabled person.

After Fletcher Allen is informed of such qualifying events or becomes aware of other events, such as death, termination or employment, reduction in hours or entitlement to Medicare benefits, Fletcher Allen will send notification to the third party administrator who will then notify the eligible Participants of the cost and enrollment process.

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 the 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 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, 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. Failure to make the initial or any subsequent payments in accordance with the due dates established will result in cancellation of coverage.

If you and a covered family member elect continuation coverage due to termination of employment or reduction in hours, your covered family member may elect an additional continuation period of up to 18 months (for an overall total of 36 months) if during the initial continuation period:

- ◆ You divorce
- ◆ You die
- ◆ Your child no longer qualifies for coverage
- ◆ You become eligible for Medicare

To be eligible for the additional continuation coverage, it is your covered family member's responsibility to notify Fletcher Allen within 60 days of the occurrence of one of these events so the third party administrator can be notified in a timely manner.

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 you or the qualifying family member become entitled to benefits under Medicare, if the Medicare entitlement date is after the date that you or your qualifying family member elected continuation coverage
- ◆ The date upon which Fletcher Allen no longer offers medical coverage to its employees
- ◆ 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
- ◆ In the case of continuation coverage for disability, the first day of the month that begins more than 30 days after a determination that you or your family member are no longer disabled under the Social Security Act.

* Please note that you or your family member are responsible for notifying Fletcher Allen within 30 days of the date of any final determination that you or your family member are no longer disabled.

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

NOTE: *You or your family member may also be eligible to pay for continuation coverage if you or your family member go on qualified military leave. Please contact the Fletcher Allen Human Resources department for more information if this situation applies to you.*

CONTINUATION OF COVERAGE DURING MILITARY LEAVE
(USERRA)

If you are covered by the Plan and enter the United States Armed Forces (including the United States Armed Forces, the Coast Guard, the Army National Guard, the commissioned corps of the Public Health Service, and certain other categories of service), you may be entitled to continue your (and your family members') health coverage under the Plan during your military service for a period of up to 18 months. If your military service is 30 days or less, your coverage continues at the same cost as before. As long as the ordinary participant premiums are paid, your coverage continues. If your military service exceeds 30 days, you will need to pay the applicable COBRA premium in order to remain covered.

Even if you do not elect to continue coverage during your military service, you may be entitled to have your coverage reinstated when you return to employment with Fletcher Allen following honorable discharge, provided that you return to employment within the time periods prescribed by law. No waiting period or exclusion will be imposed in connection with such reinstatement (unless the waiting period or exclusion would have been imposed if you remained covered during your military service) except in the case of Sickness or Injury determined by the Secretary of Veterans' Affairs to be connected with your military service. Separation for uniformed service that is dishonorable or based on bad conduct, on grounds less than honorable, AWOL, or ending in a conviction under court martial would disqualify you from any rights under USERRA.

COORDINATION WITH MEDICARE

Generally, if you continue working at Fletcher Allen after age 65, the medical coverage provided by Fletcher Allen will be your primary medical plan while you continue working. Your spouse, even if age 65 or older, also will have the Plan as primary for his or her benefits. If the Plan is primary, Fletcher Allen will pay benefits first and Medicare will pay second. The Plan will always pay secondary to Medicare for you and your family members in those instances where Medicare is the primary payor under applicable Federal law.

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:

- a. Alcohol and drug psychosis
- b. Alcohol dependence syndromes
- c. Drug dependence
- d. 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:

- a. Apply to specific benefit categories or to all benefits;
- b. Apply to as specific time period, such as annual or lifetime, whenever the term “lifetime benefit maximum” appears, it refers to the time you or your dependants 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 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 medical care or treatment with respect to which the application of the time periods for Pre-Approval of services

- a. Could seriously jeopardize your life or health or your ability to regain maximum function, or
- b. 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) **Coinsurance**

The percentage of your covered bills that you pay.

9) **Copayment**

The predetermined fee that you pay directly to the Participating Provider when you receive services.

10) **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:

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

11) **Deductible**

The amount of expenses for covered services that a Participant must pay for himself before the Plan will begin its payments.

If two or more family members receive accidental bodily injuries in a single accident, only one deductible amount shall be required for all medical expenses and charges related to the treatment of such accidental Injuries.

12) **Durable Medical Equipment**

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

- a. Is primarily and customarily used to serve a medical purpose;
- b. Is generally not useful to a person in the absence of Sickness or Injury;
- c. Is appropriate for use in the home; and
- d. Can withstand repeated use.

13) **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 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.

14) **Employee**

The term Employee means a full-time employee of Fletcher Allen Health Care who is currently in active service and who normally works between 72 hours per pay period. It also includes a part-time Employee of Fletcher Allen Health Care who is currently in active service and who normally works between 40 to 71 hours per pay period. The term does not include employees who are classified as Per Diem or Regularly Scheduled Special (RSS).

15) **Employer**

The term Employer means Fletcher Allen Health Care and all affiliated employers.

16) **Expense Incurred**

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

17) **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:

- a. 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
- b. 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.
- c. 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.

18) **Home Health Aide**

The term Home Health Aide means a person who:

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

19) **Home Health Care Agency**

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

- a. Primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Nurse;
- b. Is run according to rules established by a group of professional persons;
- c. Maintains clinical records on all patients;

- d. Does not primarily provide custodial care; and
- e. Fulfills any licensing requirements of the state or locality in which it operates.

20) **Hospice Facility**

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

- a. Primarily provides care for terminally ill patients;
- b. Is accredited by the National Hospice Organization;
- c. Meets standards established by; and
- d. Fulfills any licensing requirements of the state or locality in which it operates.

21) **Hospital**

The term Hospital means:

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

22) **Hospital Confinement**

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

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

23) **Injury**

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

24) **Medicaid**

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

25) **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.

26) **Medically Necessary Care**

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 Participant'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 a hospital confinement. Medically Necessary inpatient care also means that the Participant's condition could not be treated safely on an outpatient basis or alternative treatment setting.

27) **Medicare**

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

28) **Mental Health and Substance Abuse Treatment**

Mental Health Treatment: A branch of Medicine that deals with the achievement and maintenance of psychological well being. Substance Abuse Treatment: Treatment for the over indulgence in and dependence on an addictive substance, especially alcohol or a narcotic drug. Also called *chemical abuse*.

29) **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.

30) **Network**

The term Network means the Physicians, pharmacies, and other health care providers who have agreed to provide covered services to Participants.

The Vermont Managed Care Network is the panel of medical services providers listed on the Fletcher Allen Preferred website (www.fahcpreferred.org) or, in the printed Vermont Managed Care Provider Directory. The CIGNA Healthcare Prescription Drug Program network of participating pharmacies can be found on the CIGNA website (www.CIGNA.com). The CIGNA Behavioral Healthcare Network information can be obtained on the CBH website (www.cignabehavioral.com) or by calling 1-800-554-6931.

31) **Nurse**

The term Nurse means a Registered Professional Nurse, 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.”

32) **Out of Network**

Providers or services, that are not participating with Vermont Managed Care, CIGNA Behavioral Health Care or CIGNA Healthcare Prescription Drug Program.

33) **Out-of-Pocket Maximum**

The total amount of coinsurance expenses for covered services that the Participant is subject to each calendar year for those particular services to which the Out-of-Pocket Maximum applies.

- a. The individual out-of-pocket maximum applies separately to each Participant;
- b. The family out-of-pocket maximum applies collectively to all covered Participants in the same family. When the family out-of-pocket maximum is reached, the Plan will pay 100% of specific covered services for all covered family members during the remainder of the calendar year, subject to Plan maximums.

The out-of-pocket limit excludes co-payments and amounts paid in excess of Benefit Maximums. Coinsurance amounts paid by you are included.

34) **Participant**

The term Participant includes Employees and family members who meet the Plan’s eligibility requirements, or who are eligible for continuation coverage under COBRA or Uniformed Services Employment and Reemployment Rights Act (USERRA), and who have elected coverage under the Plan.

35) **Participating Provider**

The term Participating Provider means a Provider that has contracted with the Plan, or on whose behalf a contract has been entered into with the Plan to provide covered services to Participants.

Participating Provider contracts may include incentives to deliver services in a cost-effective manner. The Participating Providers may change from time to time. A list of the current Participating Providers is available at www.fahcpreferred.org. The CIGNA Healthcare Prescription Drug Program network of participating pharmacies can be found on the CIGNA web-site (www.CIGNA.com). The CIGNA Behavioral Healthcare Network information can be found on the CBH website (www.cignabehavioral.com) or can be obtained by calling 1-800-554-6931.

36) **Pharmacist**

The term Pharmacist means a specialist in formulating and dispensing medications. Pharmacists are licensed by the various states to practice pharmacy.

37) **Physician**

The term Physician means a licensed medical practitioner who has completed the education necessary and holds the degree of MD, DO or a graduate of a foreign education program recognized by VMC to qualify as a physician who is practicing within the scope of his/her license and who is licensed to prescribe and administer drugs or to perform surgery. It also includes 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:

- 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 Physician.

38) **Plan**

The Fletcher Allen Preferred Medical Plan.

39) **Plan Year**

January 1 - December 31

40) **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 service.

41) **Prescription Drug**

Prescription Drug means:

- a. A drug which has been approved by the Food and Drug Administration for safety and efficacy; or
- b. Certain drugs approved under the Drug Efficacy Study Implementation review; or
- c. 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
- d. Injectable insulin.

42) **Primary Care Physician (PCP)**

The term Primary Care Physician means a Physician:

- a. Who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and
- b. Who has been selected by you, as authorized by Vermont Managed Care to provide or arrange for medical care for you or any of your covered family members.

43) **Provider**

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

44) **Psychiatrist**

Doctors who have a specialty in Psychiatry or Addiction Medicine. In addition to diagnosing problem and treating them through talk therapy, an M.D. or D.O. can prescribe medication for your behavioral health problems if necessary. Many psychiatrists also have subspecialties such as: Children and Adolescents; Geriatric; Addiction Medicine, etc.

45) **Psychologists and Masters level therapists**

These are therapists-psychologists (i.e., LP), family therapists (i.e., LMFT, LMC), social workers (i.e., LCSW, LSW), nurse practitioners (i.e., ARNP, APRN), and clinicians (i.e., LMHC)- who primarily use talk therapy to help you assess the difficulty you are experiencing and identify solutions. All therapists should be licensed.

46) **Reasonable and Customary Charge**

A charge will be considered Reasonable and Customary if:

- It is the normal charge made by the provider for a similar service or supply; and
- 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.

With respect to a Participating Provider, the Reasonable and Customary Charge means the allowable amount under the Participating Provider's contract to provide covered services to Participants.

47) **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.

48) **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.

49) **Skilled Nursing Facility (SNF)**

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

- a. Physical rehabilitation on an inpatient basis; or
- b. Skilled nursing and medical care on an inpatient basis;

But only if that institution:

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

50) **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.

51) **Urgent Care**

Medical Care or treatment that must be provided within 48 hours to:

- a. Preserve your life, health, or ability to regain maximum function, or
- b. Treat severe pain that cannot be adequately managed without the care or treatment.

ERISA RIGHTS

As a Participant in the Fletcher Allen Preferred 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 Pension and Welfare Benefit 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.

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

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.

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 pre-existing 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, including your Employer or any other person, may fire you or otherwise 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 Pension and Welfare Benefits 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 Preferred Medical Plan

Plan Sponsor

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

Employer Identification Number

- ◆ 03-0219309

Plan Number

- ◆ 862

Type of Plan

- ◆ Group Health Plan

Type of Administration

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

Type of Funding

- ◆ The Plan is funded by Fletcher Allen through Employer and Employee contributions

Plan Administrator

- ◆ Fletcher Allen Health Care
111 Colchester Avenue
Burlington, VT 05401
(802) 847-2825, Option #2

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

Claims Administrators

- ◆ Apex Benefit Services (*medical services*)
PO Box 3620
Akron, OH 44309-3620
(330) 379-5511
- ◆ CIGNA Behavioral Health (*mental health and substance abuse*)
P.O. Box 46270
Eden Prairie, MN 55344-6270
(800) 926-2273
- ◆ CIGNA Healthcare Prescription Drug Program (*prescription drugs*)
P.O. Box 780
Hartford, CT 06142-0780
(800) 622-5579

Agent for Service of Legal Process

- ◆ Manager of 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

Medical Appeals

Vermont Managed Care, Inc. administers a process for Fletcher Allen Preferred Medical Plan Participants 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 claim denials made by Vermont Managed Care. An employee participant 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 Employee 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 Employee'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.

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.

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).

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 VMC

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 members of Vermont Managed Care's Care Management Committee. The Care Management Committee is a committee of Vermont Managed Care's Board of Directors, and is comprised of physicians and VMC staff members. The decision on your appeal will be made by physicians, none of whom will have been involved in the original denial of your claim or review of your first appeal.

If VMC 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 Vermont Managed Care's Care Management Committee. The Care Management Committee is a committee of Vermont Managed Care's Board of Directors, and is comprised of physicians and VMC staff members. The decision on your appeal will be made by physicians, none of whom 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 committee members and you may participate in the

meeting to provide information in support of your second appeal. The committee members 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 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 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. 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.

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.

♦ *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, and VMC staff members. The decision on your appeal will be made by physicians, none of whom 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 committee members and you may participate in the meeting to provide information in support of your second appeal. The committee members 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.

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

Mental Health/Drug and Alcohol Abuse Appeals

The CIGNA Behavioral Health (CBH) appeals process follows the standards of the American Accreditation Healthcare Commission (AAHCC – formerly URAC) and National Committee on Quality Assurance (NCQA). We have detailed each step of our appeals process.

Step 1

Call CIGNA Behavioral Health at 1-800-554-6931 and speak to a representative if you have a complaint or question about the following:

- Denial of mental health or substance abuse treatment claims
- Denial of mental health or substance abuse services
- Quality of care with CBH participating providers

If we can resolve your question or complaint at the time of your call, no further action will be taken by CBH. Should CBH not be able to resolve your complaint or question to your satisfaction, you have the option to request an appeal.

Whenever you take a step in the appeal process outlined in Step 2-4, CBH will send you a letter acknowledging your appeal request and containing instructions for the next step. Be sure to retain this letter for your reference.

Response Time Frame for an Appeal:

Varies according to level of appeal. See the following steps.

Step 2

Peer-to-Peer Review: Initial Determination.

If you or your provider are not satisfied with the initial determination of the Clinical Review process with the CBH Care Manager – the process that determines benefit payment based on a combination of your provider's recommendation and CIGNA's Behavioral Health's level of care guidelines – either of you may contact the Care Manager (an employee of CIGNA holding a degree in psychology, human services or a related field who acts as a consultant

for your provider). He or she will organize a peer-to-peer review, in which your case will be discussed between your provider and another clinician who has the same or similar licensure.

If this does not resolve your concern, CBH will (when appropriate), contact you or your provider, offering an expedited 1st level appeal by phone. If an expedited appeal is not appropriate, a standard 1st level appeal will be offered. You or your provider can request a standard 1st level appeal within no more than 365 days of the determination.

Response Time Frame:

- Inpatient peer-to-peer reviews will be scheduled within 24 hours.
- Outpatient peer-to-peer reviews will be scheduled within 5 business days.

Step 3

1st Level Appeal

In this process, another clinician holding the same licensure as your provider will independently review your case. If the determination for benefit payment is not satisfactory to you, CBH will communicate by phone and in writing with you, or your provider (whomever has requested the appeal), providing instructions for initiating a 2nd level appeal. You are responsible for the release of your medical records in order for this process to take place.

At the end of each level of appeal, a written notification of the final outcome and resolution, including the clinical explanation for benefit determination, will be sent to you, your provider, or facility.

Response Time Frame:

Standard appeals will be completed within 15 calendar days of your request if you are still in treatment and 30 days if you have completed treatment. Expedited appeals will be completed within 24 hours of the receipt of the request from your provider for urgent treatment issues.

Step 4

2nd Level Appeal

CIGNA Behavioral Health's Formal Appeals Committee reviews all 2nd level appeals *with your approval or written request*. The Committee reviews for medical necessity and coverage under your benefit plan. This committee is comprised of medical management, risk management, account management, claims/customer service and your appeals advocate – a CBH employee who assures that you have access to all your legal rights of appeal. At this level of

appeal, you, your provider or anyone you delegate has the right to participate by phone in the review process.

Response Time Frame:

Hearings occur within 30 days of the 2nd level appeal request. Standard appeals will be completed within 15 calendar days if you are in treatment or waiting for admission to treatment, and 30 days if you have finished treatment. Expedited appeals will be completed within 24 hours of the receipt of the appeal for urgent care.

If you are not satisfied with the decision reached by the Formal Appeals Committee, you may be eligible for a final level appeal with your Plan Administrator as outlined in the response letter you will receive. We will send any information relevant to the next level of appeal upon the receipt of your written release of information.

Prescription Drug Appeals

Denial of Claims for CIGNA Healthcare Prescription Drug Program

If you feel your prescription drug claim deserves further consideration, you may appeal this decision. Be sure to include additional information which will support your request. This will assist CIGNA Healthcare Prescription Drug Program in the review of the claim. You may appeal in writing to:

- ◆ CIGNA Healthcare Prescription Drug Program
Attn: Appeals
P.O. Box 780
Hartford, CT 06142-0780

Fletcher Allen Health Care Medical Plans

Privacy Notice

A federal Law, the Health Insurance Portability and Accountability act of 1996 (HIPAA), requires that health plans protect the confidentiality of your 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 the 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 Barbara Drapola, Privacy Officer, Vermont Managed Care.

HIPAA SECURITY STANDARDS ADDENDUM**AMENDMENT TO THE FLETCHER ALLEN PREFERRED MEDICAL PLAN, EFFECTIVE APRIL 21, 2005**

This Amendment is intended to bring the Fletcher Allen Health Care Employee Group Health Plan ("Plan") into compliance with the requirements of 45 C.F.R. § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162 and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information. The obligations set forth below are effective on the later of April 21, 2005 or the effective date of this Amendment.

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 Preferred 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 Preferred 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 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.