

STATE OF VERMONT
GROUP HEALTH BENEFIT
PLAN DOCUMENT

Revised May 2014

TABLE OF CONTENTS

	<u>TOPIC</u>	<u>PAGE</u>
I.	INTRODUCTION	4
II.	ELIGIBILITY FOR COVERAGE	4
III.	ENROLLMENT FOR AND START OF COVERAGE	6
IV.	PAYMENT FOR COVERAGE	15
V.	CHANGING COVERAGE DURING THE YEAR	17
VI.	WHEN COVERAGE ENDS	18
VII.	EXPENSE COVERAGE	20
VIII.	OUT-OF-POCKET EXPENSES	21
IX.	DESCRIPTION OF COVERED SERVICES AND SUPPLIES	25
X.	HOW TO USE THE PLAN	42
XI.	UTILIZATION MANAGEMENT	44
XII.	APPROVALS AND APPEALS	51
XIII.	EXCLUSIONS	63
XIV.	CLAIMS INFORMATION	71
XV.	DUPLICATE COVERAGE OF ELIGIBLE EXPENSES	72
XVI.	WORKER'S COMPENSATION	79
XVII.	THIRD PARTY LIABILITY	79
XVIII.	EXTENSION AND CONTINUATION OF BENEFITS COVERAGE	81
XIX.	CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS	87
XX.	PLAN ADMINISTRATION	88
XXI.	PLAN TERMS, AMENDMENTS, ASSOCIATED DOCUMENTS AND TERMINATION	89

XXII. PRACTICE OF MEDICINE	90
XXIII. RELEASE OF INFORMATION	90
XXIV. HEADINGS THAT DUE NOT MODIFY PLAN PROVISIONS	91
XXV. PLAN INFORMATION, ADDRESSES, AND PHONE NUMBERS	91
XXVI. SEVERABILITY	92
XXVII. DEFINITIONS	93
XXVIII. SCHEDULE OF BENEFITS	Attachment

I. INTRODUCTION

This document describes the medical benefit plan (Plan) available to State of Vermont employees and their dependents, retirees and their dependents, and other groups of individuals and their dependents associated with State government as defined in 3 V.S.A. § 631, except for the Vermont State Employees Credit Union. The Plan provides various benefit options described in the Schedules of Benefits.

II. ELIGIBILITY FOR COVERAGE

A. Employees, Legislators, Special Groups and Retirees

State of Vermont Employee

- A classified or exempt permanent employee of the State of Vermont who is expected to work at least 1040 hours per calendar year. The Commissioner of Human Resources may require certification that any employee or group of employees initially meets and continue to meets this requirement.
- A member of the general assembly (legislators)
- A session employee of the legislature or the legislative council (3 V.S.A. § 631).

Special Groups

A permanent employee of the Vermont State Employees' Association, Inc., the Vermont Historical Society, or the Vermont Council on the Arts who is expected to work at least 1040 hours per calendar year. All groups cited in the above two sentences are collectively referred to elsewhere in this document as Special Groups (3 V.S.A. § 631).

State of Vermont Retirees

For the purposes of health plan eligibility, a retiree is defined as a State employee who ceases active State employment while covered under the Plan and is determined to be eligible to continue health insurance per 3 V.S.A. § 631, 3 V.S.A. § 500, or 3 V.S.A. § 479(a)(B). Other than Group C and Group F retirement plan members as outlined below, retirees who upon retirement, do not continue enrollment in the plan without an interruption in coverage between active employment and their status as a retiree, cannot elect to participate in the Plan at a later date. (Coverage via COBRA is considered continued enrollment and is not considered an interruption in coverage.) A retiree who elects to continue coverage in retirement must have been a Member of the Plan immediately prior to, up to and including the date of retirement. A retiree who is not in the plan cannot enroll in the Plan.

Effective July 1, 2007, 3 V.S.A. § 479(b) provides that members of the Group C retirement plan who separate from service prior to being eligible for retirement benefits, who have at least 20 years of creditable service, and who actively participated in the Plan at the time of separation from service, shall have a one-time option at the time retirement benefits commence, to

reinstate the same level of coverage in the Plan that existed at the date of separation from service.

The only other instance in which a break in coverage is allowed is in the case of a former employee who had coverage upon termination of employment, dropped coverage and was subsequently granted disability retirement. These employees will be eligible for coverage from the date they became disabled, as determined by the Retirement Board. However, they must apply for coverage within 60 days of the decision of the Retirement Board and they must make their premium contribution retroactive to the date of disability. An Enrollment/Change Application must be submitted to change from COBRA coverage to coverage as a disabled retiree if the disabled retiree maintained COBRA coverage through the date of disability. Any premium paid for coverage after the date of disability while awaiting the disability decision from the Retirement Board will be refunded back to the date of disability (See Section IV). The disabled retiree will have their contribution of premium as disabled retiree withheld from their disability pay retroactive to the start date of coverage.

Employee's who terminate employment and who are eligible to receive a pension at a later date (vested terminated employees) are not eligible for coverage upon termination except as described elsewhere in this document.

Special Group Retirees

For the purpose of health plan eligibility, a retiree is defined as an employee of a Special Group identified in 3 V.S.A. § 631 who was covered by the Plan when s/he ceased active employment with the Special Group and had 1) twenty creditable years of service with the same Special Group, or 2) at least 15 years of creditable service with the same Special Group and who had attained the age of 62. Retirees who do not continue enrollment in the Plan upon retirement without an interruption in coverage between active employment and their status as a retiree may not elect to participate in the Plan at a later date. (Coverage via COBRA is considered continued enrollment and is not considered an interruption in coverage).

All of the individuals eligible for coverage identified in this section (II.A.) are collectively referred to as Employees throughout the remainder of this document.

An Employee who is working and eligible for coverage as well as their Eligible Dependents may enroll in any benefit option offered by the Plan. However, enrollment in some benefit options may not be available to retirees if the retiree is Medicare eligible or an Eligible Dependent of the retiree to be enrolled is Medicare eligible.

Except as specified above, temporary personnel, contractual personnel, members of board or commissions, persons whose compensation for service is not paid from the State treasury and any elected or appointed official who is not actively engaged in and devoting substantially full time to

the conduct of business of his or her public office are not eligible to participate in the Plan (3 V.S.A. § 635).

B. Dependents

A dependent is eligible for coverage if s/he is an Eligible Dependent of the Employee who has elected coverage for himself/herself. Civil Union partners, same sex marriage spouses, and Domestic Partners who are Eligible Dependents, are those of active State employees who are Eligible Employees.

On or after August 1, 1994, when Domestic Partner coverage was extended to active State employees, Domestic Partners of active State employees who then retire with coverage, will continue to be eligible for such coverage. Domestic Partners of Eligible Employees from Special Groups are not Eligible Dependents, and Domestic Partners of retired State employees who are not enrolled in the Plan may not be enrolled into the Plan.

III. ENROLLMENT FOR AND START OF COVERAGE

A. Enrollment is Required for Coverage

An Employee and his/her Eligible Dependents may become covered under the Plan only upon submission of a completed Enrollment/Change Application to the Employee Benefits Division of the Department of Human Resources.

B. Enrollment Upon Hire

Employees who desire coverage for themselves and their Eligible Dependents must be enrolled no later than 60 days after the Employee's Date of Hire (the Initial Enrollment Period), via the submission of a completed Enrollment/Change Application. Legislators must submit a completed Enrollment/Change Application within 60 days of taking office.

Employees who are enrolling Eligible Dependents must provide documentation of those Eligible Dependents in addition to a completed Enrollment/Change Application. This includes copies of marriage certificates/licenses for spouses and birth certificates for children.

In addition to a completed Enrollment/Change Application, enrollment of Domestic Partners requires the submission of a completed and notarized Domestic Partner Application and enrollment of Civil Union Partners requires submission of a tax declaration form.

1. Start of Coverage

If the Employee Benefits Division receives a completed Enrollment/Change Application within 30 days of an Employee's Date of Hire (30-day waiting period), coverage begins on the 31st day after the Date of Hire. If an Employee fails to enroll within 30 days of the Date of Hire, but enrolls within the next 30 days, coverage begins on the date the Enrollment/Change Application

is received by the Employee Benefits Division. Coverage of enrolled Eligible Dependents begins on the date the Employee's coverage begins if enrolled within the Initial Enrollment Period and the dependent's enrollment information is received on the same date as the Employee's information. If an Employee enrolls after the 30-day waiting period but the 60th day of employment and the Employee's dependents are enrolled after the Employee but no later than the 60th day of employment, then coverage for the dependents will begin the date the Enrollment/Change Application is received by the Employee Benefits Division. An Employee may enroll and have coverage without fulfilling the 30-day waiting period if the Employee has coverage under another healthcare plan and the Employee's coverage terminates during or immediately before the 30-day waiting period. "Immediately before" means up to three days before the Date of Hire. For example, the initial 30-day waiting period will be waived if prior coverage ends on a Friday and the Date of Hire is the following Monday or the next State business day.

2. Failure to Enroll During the Initial Enrollment Period

If an employee does not enroll during the Initial Enrollment Period, the Employee will not be able to enroll him/herself and/or any Eligible Dependent(s) until the next Annual Open Enrollment unless the Employee and/or the Employee's Eligible Dependent(s) qualify for the Special Enrollment described in Section D, Special Enrollment.

C. Annual Open Enrollment

1. Open Enrollment Period

The Open Enrollment period is the period of time during the month of November, unless otherwise mutually agreed upon by the State and the Vermont State Employees' Association, Inc. (VSEA), during which Employees in Section II of this document may make the elections outlined below.

2. Elections Available Only During Open Enrollment

During the Open Enrollment Period, Employees may, subject to the limitations specified elsewhere in this document, elect to:

- a. Enroll themselves and Eligible Dependents in one of the Plan options for the first time;
- b. Add Eligible Dependents to coverage if the Employee is a Member of the Plan; and/or
- c. Elect a different Plan option.

Note: Employees may remove themselves and any Covered Dependents from coverage at any time. If the employee discontinues coverage for him/herself, coverage for their Covered Dependents will cease simultaneously.

Annual Open Enrollment is the only time an Employee may change from one Plan option to another, unless:

- a. An Employee has a network-based plan, and
- b. The Employee permanently moves to an area that does not have a network.

Employees whose retirement date is January 1 may not participate in the most recent preceding Annual Open Enrollment if they are not a Member of the Plan at the time of the Annual Open Enrollment (i.e., an Employee who would not have coverage on December 31 and who will retire on January 1 may not elect coverage during the Annual Open Enrollment.)

3. Restrictions on Elections During Open Enrollment

No Eligible Dependent may be covered unless the Employee of whom they are a dependent is covered. All relevant parts of the Enrollment/Change Application must be completed and the application must be received by the Employee Benefits Division on or before the last day of the Annual Open Enrollment Period. Retirees who are not members of the Plan may not participate in the Annual Open Enrollment. Retirees who are members of the Plan may not add a Domestic Partner. If a retiree drops coverage for a Domestic Partner, a Domestic Partner may not be subsequently added to coverage.

4. Start of or Changes to Coverage Following Open Enrollment

All initiation of coverage election or changes in coverage during any Annual Open Enrollment will become effective on January 1 of the following year.

5. Failure to Make a New Election During Open Enrollment (Covered Employees)

a. No Election Made, Previously Elected Plan Option Available in Following Calendar Year

If an Employee has been enrolled in one of the Plan options and fails to make a new plan option during the Annual Open Enrollment period, the Employee will be considered to have made an election to continue with the current plan option coverage they had during the Annual Open Enrollment.

b. No Election Made, Previously Elected Plan Option Not Available in Following Calendar Year

An Employee will not have any coverage in the new Plan Year if:

- Their plan option in effect during the Annual Open Enrollment period will not be available in the new Plan Year, and
- They fail to elect a plan option available the following Plan Year.

Active Employees will not be able to select a Plan option after the Annual Open Enrollment period unless they or their Eligible Dependents qualify for Special Enrollment. Retirees who fail to elect a new Plan option when their current Plan option will not be available in the upcoming Plan Year, will lose coverage permanently on December 31 of the year in which their current plan is terminated.

6. Failure to Enroll During Open Enrollment

An Employee who fails to enroll him/herself and/or any of his/her Eligible Dependents during the Annual Open Enrollment will not be able to enroll him/herself and/or any Eligible Dependents until the next Annual Open Enrollment period, unless the Employee and his/her Eligible Dependents qualify for Special Enrollment.

D. Special Enrollment

1. New Acquired Eligible Dependent

If a Covered Employee acquires an Eligible Dependent through a qualifying event, that Eligible Dependent may be enrolled no later than 60 days after the date they became an Eligible Dependent. However, a retired Employee may not add a Domestic Partner.

If an Employee who is not covered and not retired acquires an Eligible Dependent through a qualifying event, the Employee may enroll him/herself and the new Eligible Dependent and any other Eligible Dependents no later than 60 days after the qualifying event.

If an Employee who is not retired did not enroll his/her Spouse or Partner for coverage within 60 days of the date on which Spouse or the Partner became an Eligible Dependent, and if the Employee subsequently has a qualifying event through which they acquire an Eligible Dependent child, the Spouse or Partner together with the new dependent child may be enrolled no later than 60 days after the date the child became an Eligible Dependent (e.g., birth date or date on which child was placed for adoption). The Employee does not have to be enrolled prior to enrolling the Spouse or Partner with the child, but the Employee must enroll him/herself to enroll the Spouse or Partner and the child.

If an Employee who is a retiree and a member of the Plan did not enroll their Spouse or Civil Union Partner for coverage within 60 days of the date on which the Spouse or Civil Union Partner became an Eligible Dependent, and the Employee who a retiree subsequently acquires a child who is an Eligible Dependent, the Spouse or Civil Union Partner and the newly acquire dependent child may be enrolled no later than 60 days after the date the child became an Eligible Dependent (e.g., birth date or date on which child was placed for adoption).

Dependent Children who are adopted or are in placement awaiting adoption and who are enrolled within 60 days of adoption or placement for adoption, will be eligible for coverage from

the date the child is adopted or placed for adoption with the Employee, but in no instance will coverage be retroactive more than 60 days from the date the Employee Benefits Division receives the Enrollment/Change Application. A child is placed for adoption on the date the Employee becomes legally obligated to provide full or partial support and the Employee is in the process of adopting the child. However, if a child is placed for adoption, and if the adoption does not become final, coverage of that child will terminate as of the date the Employee no longer has a legal obligation to support that child.

2. Loss of Other Coverage

If:

- a.** an Employee who is **not retired** did not enroll him/herself or any Eligible Dependents within 60 days after the date on which the Employee or the Eligible Dependents first became eligible to enroll for coverage because the Employee or the Eligible Dependents had health care coverage under another health plan, including COBRA Continuation Coverage, individual insurance, Medicare, Medicaid, TRICARE, or other public program; and
- b.** the Employee and/or any Eligible Dependents lose coverage from the other health plan through no fault of their own, to include exhaustion of COBRA coverage, death of a Spouse, Domestic Partner or Civil Union Partner, divorce, dissolution of a domestic partnership or civil union, or loss of a job, the Employee may enroll him/herself and/or his/her Eligible Dependents (as long as the Employee is enrolled) within 60 days after the termination of coverage under that other health plan.

If:

- a.** an Employee who is **retired** and covered did not enroll an Eligible Dependent within 60 days after the date on which the Eligible Dependent first became eligible to enroll for coverage because the Eligible Dependent had health care coverage under another health plan, including COBRA Continuation Coverage, individual insurance, Medicare, Medicaid, TRICARE, or other public program; and
- b.** the Eligible Dependent loses coverage from the other health plan through no fault of their own, to include exhaustion of COBRA coverage, the Employee may enroll his Eligible Dependent within 60 days after the termination of coverage under that other health plan.

COBRA Continuation Coverage is exhausted if it ceases for any reason other than:

- a.** the failure of the individual to pay the applicable COBRA premium on a timely basis, or
- b.** for cause (e.g., making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage).

A permanent move to an area that is not a service area of the COBRA HMO or similar program (whether or not by the choice of the individual) constitutes exhaustion of COBRA Continuation Coverage.

3. Return To Work

If an Employee who was enrolled in a Preferred Provider Organization (PPO) Plan option returns to work after a break in coverage, and is eligible to re-enroll and re-enrolls, all accumulations toward Annual and Limited Lifetime Maximum Benefits (utilization and expenses) that were incurred prior to the break in coverage will apply. Accumulations towards annual Deductibles will also apply if they return to work in the Plan Year in which they left. If Eligible Expenses were incurred in October, November, or December of the year in which they left work and those expenses were applied to their medical or mental health and substance abuse healthcare Deductibles, the amounts applied to the Deductibles will be carried forward and applied towards the Deductibles of the following Plan Year.

a. Reduction in Force (State Employees Only)

Former State employees who were laid off in a Reduction in Force (RIF) and did not maintain coverage, may enroll themselves and their Eligible Dependents in the Plan within 60 days of return to active State service through exercise of RIF rights if they meet the eligibility requirements outlined in Section II of this Plan Document. In this instance, there is no 30-day waiting period. The employee must re-enroll in the same plan option they had prior to being laid off if that plan is still available, unless an Open Enrollment period has passed. Eligible Dependents may be enrolled whether or not they were previously enrolled. If an Employee did not have coverage when laid off, the Employee may enroll as a new hire upon return to active State service through exercise of RIF rights. However, he/she is subject to a 30-day waiting period.

b. Parental and Family Leave or Military Leave (all Employees)

Employees on Parental and Family Leave (21 V.S.A. § and 29 U.S.C § 2601 *et.seq.*) or Military Leave whose coverage ended while on leave may have coverage reinstated upon return to work if they return promptly at the end of that leave and elect to reinstate coverage. They must enroll in the same plan option they had prior to going on leave status unless they have missed the opportunity to change plans during an open enrollment which occurred while on leave status. If they missed an open enrollment, they may re-enroll in a different plan option. Eligible Dependents may be enrolled whether or not they were previously enrolled.

c. All Other Leave of Absence (all Employees)

Any employee on an approved leave of absence (medical or non-medical, paid or unpaid) or permanent Employee who dropped coverage while in a leave or in an inactive status, may not be reinstated upon return to active status. They must wait until the next Annual Open Enrollment period or they experience a qualifying event. Even though and Employee

dropped coverage during a leave of absence, the period without coverage will not be counted as a break in coverage as required by State or Federal laws (e.g. Vermont Parental and Family Leave law and the Uniformed Services Employment and Re-employment Act).

4. Special Enrollment – ESIA

In 2007, 33 V.S.A. §1974 was amended to include as a qualifying event, the determination of the Agency of Human Services of eligibility for Employee Sponsored Insurance Premium Assistance (ESIA). If the Agency of Human Services finds an Employee eligible for ESIA, the Employee may enroll within 30 days of the eligibility determination, rather than waiting until the next Open Enrollment period.

5. Special Enrollment – Documentation Required

Effective 09/01/2009, an Employee who wishes to add an Eligible Dependent to the Plan based on an approved qualifying event, must provide proof of the event. For example, If an Employee is married and wishes to enroll the newly acquired spouse, a copy of the marriage certificate is required with Enrollment/Change form. If the Enrollment/Change form is submitted without the required documentation, there may be a delay in the start of the coverage until acceptable documentation is received. Employees who are adding a domestic partner or same sex partner must also complete either the “Domestic Partner Application and Policy” form or the “Qualified Dependent Declaration” form.

6. Start of Coverage Following Special Enrollment

a. Newborn Children of an Enrolled Employee

A newborn child or an enrolled Employee is covered from birth to 60 days of age without any enrollment action required. However, the employee must enroll the child within 60 days of birth to obtain coverage beyond 60 days.

b. Newborn Children of a Covered Child

A newborn child of a Covered Child is covered for 31 days but is not an Eligible Dependent.

c. Adopted Children

Adopted or placed children are covered for 60 days from date of birth, placement or adoption, but this coverage is not automatic. The Employee Benefits Division must receive and Enrollment/Change Application within 60 days of birth, placement or adoption, for coverage to be effective as of the date of birth, placement or adoption, respectively.

d. Other Enrollees

Except for the coverage of a newborn or an adopted child, coverage for Employees and coverage of other Eligible Dependents will become effective on the date the Enrollment/Change Application is received by the Employee Benefits Division, subject to the Employee Benefits Division receiving the completed application within 60 days from the

date the event which qualified the Employee or the Eligible Dependents for coverage. However, if Eligible Dependents and/or Employee are covered due to the acquisition of a dependent child, coverage will be effective on the date of birth, adoption, or placement for adoption. If an Employee or Eligible Dependent becomes eligible for Special Enrollment due to the loss of coverage from another plan, coverage from this Plan will not begin until coverage from the other plan has terminated.

7. Failure to Enroll During Special Enrollment

If an Employee fails to enroll him/herself and/or any Eligible Dependents, including newborn children, within 60 days after the date on which they first became eligible for Special Enrollment, the Employee will not be able to enroll him/herself or any Eligible Dependents until the next Annual Open Enrollment period.

E. When an Employee and Any Eligible Dependents are Eligible Employees

If an Employee and a Spouse or Partner are Eligible Employees, both may enroll as individuals or one may enroll the other as a dependent. If each Eligible Employee enrolls as an individual, all children for whom coverage is elected must be enrolled by one Eligible Employee. If enrolled separately, out-of-pocket maximum limits will be determined independently for each Covered Employee.

No individual may be covered under the Plan both as an employee and as a dependent, nor may any Eligible Dependent be enrolled by more than one employee.

If, while family coverage is in effect, any Covered Child becomes an Eligible Employee, the Covered Child shall cease to be covered as a dependent as of the date the child is eligible to be covered as an Employee.

F. Qualified Medical Child Support Orders (QMCSOs)

According to Federal Law, a Qualified Medical Child Support Order, or QMCSO, is a child support order of a court or state administrative agency (usually resulting from a divorce or legal separation) that has been received by the Plan, and that:

1. Designates one parent to pay for a child's health plan coverage;
2. Indicates the name and last known address of the parent required to pay for the coverage, and, the name and address of each child covered by the QMCSO;
3. Contains the reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
4. States the period for which the QMCSO applies: and

5. Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not provide, or if it requires an Employee who is not covered by the Plan to provide coverage for a dependent child, except as require by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will the force and effect of law, and the order must be issued through and administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for an Eligible Dependent of an Employee, the Plan Administrator will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on the Employee, the other parent, the child, and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the Employee is covered by the Plan, the Plan Administrator will notify the parents and each child to be covered, and advise them of the procedures that must be followed to provide coverage.

If the Employee is a participant in the Plan, the QMCSO may require the Plan to provide coverage for the Employee's Eligible Dependents, who are children, and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept a Special Enrollment of the Dependent Child(ren) specified by the QMCSO from either the Employee or the custodial parent. Coverage of the child(ren) shall become effective as of the date the Enrollment/Change Application is received by the Plan, and shall be subject to all terms and provisions of the Plan, including the limits on selection of provider and requirements for authorization of services, insofar as is permitted by applicable law.

If an Employee is not a participant of the Plan at the time the QMCSO is received and the QMCSO orders the Employee to provide coverage for the Eligible Dependent child(ren) of the Employee, the Plan will accept a Special Enrollment of the Employee and the child(ren) specified by the QMCSO. Coverage of the Employee and the child(ren) shall become effective as of the date the Enrollment/Change Application is receive by the Plan, and shall be subject to all terms and provisions of the Plan.

No coverage will be provided for any child(ren) under a QMCSO unless the applicable Employee contributions for that child's coverage are paid, and all of the Plan's requirements for coverage of that child have been satisfied. Contributions required for coverage under a QMCSO are the total employer contributions required for coverage of the Employee and all members of the Employee's family who are enrolled in the Plan, minus the contributions being paid by the Employees.

Coverage a Dependent Child under a QMCSO will terminate when coverage of the Employee-parent terminates for any reason, including failure to pay any required contributions, subject to the dependent child's right to elect COBRA Continuation Coverage if that right applies.

For additional information regarding the procedures for payment of claims under QMCSOs, see the Claims Information section of this document.

IV. PAYMENT FOR COVERAGE

If an Employee is eligible for and wishes to elect coverage under the Plan, the Employee will be required to make a contribution as outlined below. Employee contributions that are not automatically deducted from a paycheck shall have a due date of the State pay date. Retirees must pay premium by the first day of each month.

STATUS	LEVELS OF MEMBER CONTRIBUTION
Employee (full or part time, actively at work or on a paid leave of absence)	20% of the published premium
Employee on an approved unpaid leave of absence for non-medical reasons	100% of published premium
Employee on an approved, unpaid medical leave of absence	20% for first twelve months of leave of absence, 100% after first twelve months
Employee on an unpaid leave of absence to serve in the General Assembly of the State of Vermont	20% of the published premium
Unpaid Military Leave	Member contributions and length of benefit continuation are based on the negotiated military leave health care benefit continuation provisions of the collective bargaining agreements then in force or state policy then in effect, but normally, 20% of the published premium
Permanent part-time employee as defined in the current labor contract in an inactive status (i.e., a regular or irregular layoff due to seasonal needs or lack of work)	100% of published premium
RIF (Reduction in Force) Employee (must retain re-employment rights under the Re-employment Rights Article of the union agreement)	<ul style="list-style-type: none"> • 20% for first six full pay periods following effective date of separation (this provision applies only to the first RIF an employee experiences as per article 49, section 4(f) of the labor agreement)

STATUS	LEVELS OF MEMBER CONTRIBUTION
	<ul style="list-style-type: none"> • 100% after first six full pay periods up to two years from date of separation at which time coverage will end (premium to be paid monthly in advance of the due date)
Legislator	100% of the published premium
Session employee of the legislature or the legislative council	100% of the published premium
COBRA beneficiary	102% of the published premium (Note: surviving Eligible Dependents who were covered at the time of an Employee's death do not begin premium payment until two weeks after the close of the pay period following death.)
Terminated Employee or Covered Dependent of a deceased or terminated Employee not eligible for coverage under COBRA where the Employee had coverage for at least three months prior to termination or death and in accordance with the provisions of 8 V.S.A § 4090	100% of published premium for a maximum of six months after the date coverage would have ended due to termination or death.
Retiree	20% of the published premium
Surviving Spouse/Covered Dependent of a deceased retiree who receives a monthly retirement allowance under the survivorship option of the State retirement system.	No contribution for the first full month after the month of death, 100% of the published premium thereafter.
Surviving Spouse/Covered Dependent of a deceased Employee who was in active service at the time of death and eligible for retirement.	No contribution for the first full pay period after the pay period in which death occurred, 20% of the published premium thereafter.
Surviving Spouse of a deceased retiree who retired due to disability after 1/1/98 and died prior to age 65 or the surviving dependents of an employee who died while in active service after 1/1/98 as specified in 3 V.S.A § 464-465 and who receive a monthly retirement benefit from the State.	20% of the published premium until eligible for Medicare or a spouse or partner through civil union is added at which time 100% of the published premium must be paid.

V. CHANGING COVERAGE DURING THE YEAR

A Covered Employee may not add dependents during the Plan Year (January 1 through December 31) unless a qualifying change in status occurs.

The following qualifying changes are the only ones permitted under the Plan:

- A.** Change in legal marital status, including marriage, divorce, legal separation, annulment, or death of a Spouse;
- B.** Change in legal civil union status, including dissolution of a civil union or death of the Civil Union Partner;
- C.** Change in Domestic Partner status, including termination of a partnership or death of the Partner;
- D.** Change in the number of Eligible Dependents, including birth, adoption, placement for adoption, or death of a Covered Dependent;
- E.** The start or termination of employment by an Eligible Dependent or Covered Dependent, or an increase or decrease in hours of employment by an Employee, and any Covered or Eligible Dependent, including a switch between part-time and full-time employment, which affects their eligibility for coverage by this Plan or another health plan;
- F.** Change in Eligible Dependent status under the terms of this Plan, including changes due to attainment of age or any other reason provided under the definition of Eligible Dependent in the Definitions section of this Plan Document;
- G.** Change required under the terms of a Qualified Medical Child Support Order (QMCSO), including a change in an Employee's election to provide coverage for the child specified in the order, or to cancel coverage for the child if the order requires the Employee's former Spouse or Partner to provide coverage;
- H.** Change consistent with an Employee's right to Special Enrollment when the Employee and/or their Eligible Dependents lose other coverage and the Employee previously declined coverage under this Plan for him/herself and/or any of the Employee's Eligible Dependents;
- I.** An Employee or a covered Eligible Dependent becomes entitled to coverage under Medicaid or Medicare.

Two rules apply to making changes to benefit coverage during the year:

- A. An Employee may only change plan options if an Employee has a network plan and the Employee moves to an area that does not have a network.
- B. To add a dependent and/or select a different coverage level, a properly completed Enrollment/Change Application must be received by the Employee Benefits Division within 60 days of the qualifying event. Otherwise, an Employee must wait until the next Open Enrollment period to make changes in coverage.

VI. WHEN COVERAGE ENDS

A. Events Causing Coverage to End

Coverage ends:

- 1. On the last day of the bi-weekly pay period in which employment ends;
- 2. When an Employee is no longer eligible to participate in the Plan; or
- 3. When an Employee ceases to make contributions required under the Plan for coverage.

If the Employee elects to cease making payments and notifies the Employee Benefits Division by submitting an Enrollment/Change Application, coverage will be terminated:

- 1. at the end of the pay period in which the Enrollment/Change Application is received by the Employee Benefits Division, if the Employee is in active service of the State, or
- 2. at the end of the month in which the Enrollment/Change Application is received by the Employee Benefits Division, if the Employee is not in active service of the State. If a Member ceases to make the total contribution required for coverage by the due date of that contribution and does not notify the Employee Benefits Division by submitting an Enrollment/Change Application, coverage will be terminated 31 days after the due date, but no earlier than 14 days from the date the Employee Benefits Division has mailed a notice of the termination to the last address of the Employee provided by the Payroll Division. If a payment for the full contribution is received by the 31st day following the due date or within 14 days of the notice sent by the Employee Benefits Division, whichever is later, coverage will not be terminated. If eligibility for continued participation in the Plan ceases because the number of hours a permanent Employee is expected to work in the calendar year is less than 1040 hours, the Employee will be given reasonable notice regarding termination of coverage and the opportunity to have a hearing before the Commissioner of Human Resources.

Coverage of Covered Dependent(s) ends:

1. on the last day of the bi-weekly pay period in which the Employee's employment ends;
2. when a Covered Dependent(s) no longer meets the definition of Eligible Dependent; or
3. when the Employee ceases to make any contributions require for the Covered Dependent's coverage.

B. Special Circumstances

1. Parental and Family Leave

Full time employees who have successfully completed their original probation or have worked for one year, are entitled, by State and Federal law, to up to 12 weeks of unpaid Family and/or Parental Leave each 12 month period beginning with the first day either type of leave is used for family or medical purposes as specified in State or Federal law (e.g., personal illness, birth or adoption of a child, or provision of care to a spouse, child or parent who is seriously ill). However, the labor agreement between the State and VSEA allows for four months of Parental Leave with the potential for a two-month extension. (The amount of leave for part-time employees is calculated on a prorated basis consistent with 29 C.F.R. 825.205.) While an Employee is officially on such a Leave, he/she may keep coverage for himself/herself and his/her Covered Dependents in effect during the leave period by continuing to pay contributions each payday.

Whether or not an Employee keeps coverage while on Parental and/or Family Leave, if the Employee returns to work promptly at the end of that Leave, their coverage and that of any dependents who were covered by the Plan at the time Leave was taken will be reinstated without any additional limits or restrictions imposed due to the Leave. Any changes in the Plan's terms, rules or practices, that went into effect while the Employee was away on Leave will apply to the Employee and his/her Covered Dependents in the same way they apply to all other Employees and their Covered Dependents.

2. Leave for Military Service

If an Employee goes into active military service, coverage will continue in accordance with the negotiated health care provision of the collective bargaining agreements then in force, or state policy then in effect.

3. Leave to Serve in the General Assembly

Employees on an unpaid leave of absence for service in the General Assembly may remain in the Plan for an approved period of leave if they continue to pay their contribution each payday. Failure to pay their contribution will result in cessation of coverage at the end of the last pay period for which a contribution was made.

4. Reduction in Force (RIF)

Employees in a RIF status who retain reemployment rights under the Reemployment Rights Article of the negotiated union agreement may continue coverage for up to two years from the effective date of separation. Contributions toward premiums will be as outlined in the Payment for Coverage section of this Plan Document.

5. Approved Leave of Absence Other than Parental/Family or Military Leave

If an Employee is on an approved, unpaid leave of absence, other than Parental, Family, or Military Leave, including a leave of absence for medical reasons that exceeds 12 weeks, or if an Employee is a permanent part-time employee in an inactive status, he/she may remain in the Plan for the approved period of leave or inactive status as long as he/she continues to pay the Member Contribution specified in Section IV on or before each pay date for which the payroll deduction of premium would normally be made.

C. Extension and Continuation of Medical Coverage

Under certain circumstances, the Employee may be able to continue medical coverage at his/her own expense for a limited period of time after and event, which may otherwise terminate coverage. See the Section XVIII for an explanation of when and how these circumstances apply to coverage.

VII. EXPENSE COVERAGE

A. Eligible Expenses

Eligible Expenses are those determined by the Plan Administrator or its designee to be for Medically Necessary services and supplies that are not in excess of Reasonable and Customary Charges, are not excluded as provided elsewhere in this Plan Document, and are not in excess of any applicable Limited Lifetime and/or Annual Maximum Benefits. Employees who are not certain that costs incurred for a service or supply will be Eligible Expenses should contact the Plan Administrator before obtaining the service or supply.

B. Non-Covered Expenses

The Plan will not reimburse an Employee for any expenses associated with services or supplies that are not determined to be Medically Necessary; that are determined to be in excess of the Reasonable and Customary Charges, that are not covered by the Plan as specified in the Exclusions section of this document; or that are determined to be in excess of any applicable Limited Lifetime and/or Annual Maximum Plan Benefits. Services or supplies not cited in the Exclusions section of this document may be excluded upon review by the Plan Administrator or its designee. Any such exclusion is subject to appeal by a Member or a designee. Members who are not certain that a service or supply is excluded should contact the Plan Administrator before obtaining the service or supply.

C. Participating Health Care Provider Services

Participating Providers have agreed to accept the amounts the Plan allows for covered services. This prevents Members from incurring charges above those, which the Plan has determined to be Reasonable and Customary. Non-Participating Providers may seek payment from Members for amounts in excess of those allowed by the Plan in addition to the Cost Share.

D. Eligible Expenses Not Payable by the Plan

Generally, the Plan will not reimburse Members for all Eligible Expenses. Members may have to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the Eligible Expenses. In addition, if a Member reaches an Annual Maximum Benefit, no additional care associated with that benefit will be covered for the remainder of the Plan Year. If a Limited Lifetime Maximum Benefit is reached, no additional care associated with that Benefit will be covered.

VIII. OUT-OF-POCKET EXPENSES

Out-of-pocket expenses a Member will incur are dependent on the plan option selected. A plan option may have separate Deductibles and Cost Shares for Eligible Medical Expenses, Eligible Mental Health and Substance Abuse Expenses and Eligible Pharmacy Expenses, or one Deductible and Cost Share that applies to all three types of expenses. See the Plan Summaries for a plan option to determine if separate Deductibles and Cost Shares apply. If separate Deductible and Cost Shares apply, see the detailed information below regarding each type of expense.

A. Deductibles

Members are responsible for paying most Eligible Expenses until the Eligible Expenses equal the Deductible(s) for the Plan Year (January to December). Then the Plan begins to pay Benefits. However, some Eligible Medical Expenses are not subject to Deductibles. See the Schedules of Benefits and the Description of Covered Services sections of this document to determine which Eligible Medical Expenses are not subject to Deductibles.

Eligible Expenses incurred by a Member in the last three months of a Plan Year which are used to satisfy all or part a Deductible for that Plan Year will be carried forward and used again to satisfy all or part of the same Deductible for that Member in the following Plan Year.

1. Medical

a. Individual and Family Deductibles

There are two types of annual Deductibles: individual and family. An individual Deductible is the maximum amount a covered individual must pay before Plan Benefits begin. A family Deductible is the maximum amount a family (defined here as an Employee and one or more Covered Dependents) is responsible for paying before Plan Benefits begin. **At least one family member must satisfy the individual Deductible.** Then, the Eligible Medical Expenses of other family members are aggregated until the family deductible is reached.

Note: A Plan Option may not have a family Deductible, in which case each person covered by the plan option must meet the annual individual Deductible.

b. In-Network and Out-of-Network Deductibles

If the Plan option selected has in-network and out-of-network Deductibles, Eligible Medical Expenses incurred from Out-of-Network Providers will be applied toward their in-network and the out-of-network Deductibles. Eligible Medical Expenses incurred from In-Network Providers will only be applied toward the in-network Deductible.

2. Mental Health and Substance Abuse

This Plan does not impose a separate deductible for Mental Health and Substance Abuse services. Eligible Mental Health and Substance Abuse Expenses are applied to the medical Deductible until that Deductible amount is reached. If a plan option has separate Deductibles for in-network versus out-of-network care and for individuals versus families, Eligible Mental Health and Substance Abuse Expenses are applied to the applicable Deductible. No Cost Sharing by the Plan will occur for Eligible Mental Health and Substance Abuse Expenses or Eligible Medical Expenses until the applicable Deductible is reached.

Some plan options may not apply any Eligible Mental Health and Substance Abuse Expenses toward the Deductibles if care is obtained from an in-network provider. In these plan options, Benefits are payable from the first visit. However, these plan options may apply Eligible Mental Health and Substance Abuse Expenses from out-of-network Providers toward the applicable Deductibles.

3. Pharmacy

There are two types of annual Deductibles for pharmacy coverage: individual and family. An individual Deductible is the maximum amount one covered individual must pay before Plan Benefits begin. A family Deductible is the maximum amount a family (defined here as an Employee and one or more covered Eligible Dependents) is responsible to pay before Plan Benefits begin. If an Employee has two or more Covered Dependents, then three family members must satisfy the individual Deductible to meet the family Deductible.

B. Cost Sharing

Once a Member has met the annual Deductible(s), the Plan generally pays a portion of the Eligible Expenses, and the Member (not the Plan) is responsible for paying the remainder. The Member's Cost Share is called a Coinsurance or Copayment. A Coinsurance is typically a percentage of the Reasonable and Customary Charge for an Eligible Expense while a Copayment (or Copay, as it is sometimes called) is a set dollar amount the Member is responsible for paying. The portion of Eligible Medical Expenses paid by the Plan and the Member for each type of Eligible Expense is specified in the Schedule of Benefits. Plans generally specify maximum cost sharing limits for Members. Once the maximum cost sharing limit is reached, a plan option may pay up to 100% of incurred Eligible Expenses until a Maximum Plan Benefit is reached.

1. Medical

a. Individual and Family Maximum Cost Shares

There are two types of annual maximum Cost Shares: individual and family. An individual Cost Share is the maximum amount one covered individual has to pay, after meeting their Deductible, for expenses incurred during a Plan Year. Once the maximum individual Cost Share has been reached, benefits for Eligible Medical Expenses incurred during the remainder of the Plan Year become payable at 100%. A family Cost Share is the maximum amount a family (defined here as an Employee and one or more Covered Dependents) is responsible for paying for Eligible Medical Expenses incurred during a Plan Year. Once the maximum annual Cost Share has been met, benefits for Eligible Medical Expenses incurred during the remainder of the Plan Year may become payable at 100%. Family maximum Cost Shares are calculated on an aggregate basis. Thus, no one family member must reach the individual Cost Share before the Plan may begin to pay Benefits at 100% of the Eligible Medical Expense, subject to limitations specified elsewhere in this document, if the family maximum Cost Share has been reached.

Notes:

- A Plan Option may not have a family maximum Cost Share, in which case each Member from the family must meet the annual individual Cost Share.
- Expenses a Member incurs due to failure to follow Utilization Management procedures or due to charges from a non-network provider in excess of Reasonable and Customary are not counted toward the maximum cost sharing limits.

b. In-Network and Out-of-Network Maximum Annual Cost Shares

If the benefit option selected has in-network and out-of-network Cost Shares, Eligible Medical Expenses incurred from Out-of-Network Providers will be applied toward the in-network and the out-of-network Cost Shares. Eligible Medical Expenses incurred from In-Network Providers will only be applied toward the in-network Cost Shares.

2. Mental Health and Substance Abuse

Some plan options may not require Cost Sharing if Mental Health and Substance Abuse care is obtained from in-network providers. However, when care is obtained from out-of-network providers, Cost Sharing is required. Mental Health and Substance Abuse Cost Shares in these plan options are not applied toward the maximum annual individual or family medical Cost Shares. In addition, no maximum individual or family Mental Health and Substance Abuse Cost Share exist for out-of-network care. Members must pay their Cost Share for every Mental Health and Substance Abuse service.

Other plan options may require Cost Sharing for all Mental Health and Substance Abuse care once a Deductible has been reached. In such plans, the Cost Sharing for Eligible Mental Health and Substance Abuse Expenses are coordinated with the Cost Shares for Eligible Medical

Expenses. This means Cost Shares for Eligible Mental Health and Substance Abuse Expenses are applied to the medical Cost Share maximum and medical Cost Shares are applied to the mental health and substance abuse Cost Share maximums. For example, if a Member meets the annual individual maximum medical Cost Share as a result of having incurred Eligible Medical Expenses and then incurs Eligible Mental Health and Substance Abuse Expenses, no additional Cost Share must be paid for the remainder of the Plan Year subject to limitations cited elsewhere in this document.

3. Pharmacy

The managed pharmacy benefit only has an individual maximum annual Cost Share. Once the maximum annual Cost Share has been met for prescription drugs dispensed in a Plan Year, all subsequent prescription drugs dispensed in the Plan Year are payable at 100% subject to the limitations outlined elsewhere in this plan. The unmanaged pharmacy benefit Cost Shares are applied to the overall individual Cost Share for the plan option. Once the overall individual Cost Share is met, all subsequent prescription drugs dispensed in the Plan Year are payable at 100%, subject to other limitations outlined elsewhere in this plan.

C. Self-Pay Expenses

1. Types of Self-Pay Expenses

In addition to Deductibles, Coinsurance and Copayments, Members are responsible for paying the following expenses:

- a. All expenses for healthcare services or supplies that are not Eligible Expenses.
- b. All charges in excess of the Reasonable and Customary Charges made by Non-Participating Providers as determined by the Plan. (Note: Benefits may not be provided for some services or supplies rendered by Non-Participating Providers such as prescriptions drugs, infertility treatment and transplants.)
- c. All charges in excess of the Annual Maximum Benefits or Limited Lifetime Maximum Benefits, or in excess of any other limitation of the Plan.
- d. Any service or supply determined to be not Medically Necessary.
- e. Expenses not paid by the Plan due to failure to follow Utilization Management procedures.

D. Re-Enrollment in Plan

A former Employee who had coverage under this Plan and who returns to active service and re-enrolls will have all accumulated Limited Lifetime Maximum Benefits (utilization and expenses) that were incurred prior to leaving the Plan reinstated upon re-enrollment. In addition, all accumulated

Annual Maximum Benefits (utilization and expenses) that were incurred prior to leaving the Plan will be reinstated upon re-enrollment if the former Employee re-enrolls in the same Plan Year.

IX. DESCRIPTION OF COVERED SERVICES AND SUPPLIES

(Note: Exclusions are listed in Section XIII of this Plan Document.)

A. Hospital Inpatient Services

1. Room and Board

The following room and board services are covered:

- a bed in a semi-private room (a room with two or more beds.),
- a bed in a special care unit if Member is critically ill,
- meals,
- general nursing services, and
- a bed in a private room only if the hospital has no semi-private rooms or a bed in a private room is Medically Necessary (e.g., patient has a contagious illness or is immunosuppressed and cannot be exposed to other patients.)

2. Ancillary Services

The following ancillary services are covered when Medically Necessary:

- operating room and supplies,
- delivery room and supplies,
- prescribed medication,
- treatment room and supplies,
- anesthesia,
- medical and surgical dressings and supplies,
- cast, splints, and braces,
- therapy services,
- laboratory and radiology services.

3. Items Not Covered

The following items are not covered when an Inpatient:

- a bed in a private room unless Medically Necessary,
- television,
- telephone, and
- any personal comfort items.

B. Hospital Outpatient Services

1. Emergency Room Services

An emergency room should be used only in the event of an emergency medical condition. An emergency medical condition means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- a. placing the Member's physical or mental health in serious jeopardy; or
- b. serious impairment to bodily functions; or
- c. serious dysfunction of any bodily organ or part.

For members admitted to the hospital because of an emergency, either immediately or after an observation stay, no Emergency Room copay will apply. Members will pay the inpatient copay in this instance. Members must notify the Plan within 48 hours of an emergency admission or as soon as reasonably possible.

2. Other Hospital Outpatient Services

The following services and supplies typically obtained on a Hospital outpatient basis are covered:

- outpatient surgery (operating room, procedure room, recovery room, and other Medically Necessary hospital services and supplies.),
- treatment rooms,
- anesthesia,
- medical/surgical dressings and supplies,
- observation stays, up to 23 hours,
- casts, splints, and braces,
- physical, speech, and occupational therapy,
- diagnostic services,
- IV medications such as antibiotics, steroids, and hemophilia agents,
- laboratory tests and imaging studies (e.g., x-rays, ultrasounds, MRIs, etc.), and
- routine mammograms.

C. Ambulatory Surgical Care

Services described in this section may be provided in a freestanding ambulatory surgical care facility or in an ambulatory surgical care facility that is co-located with a hospital:

- operating, procedure, treatment and recovery room,
- anesthesia,
- Medically Necessary services and supplies,
- casts, splints, and braces,
- IV medications, and
- Laboratory tests and imaging studies.

D. Diagnostic Services

Diagnostic services used to detect symptoms or identify an illness or injury is covered. These services may be performed in the outpatient department of a hospital, doctor's office or other setting. These services include but are not limited to:

- diagnostic imaging, which may consist of x-rays, mammograms, MRI, ultrasound, nuclear medicine studies and other approved imaging methods,
- diagnostic pathology consisting of laboratory and pathology tests,
- ECG, EEG, EKG, and other diagnostic medical procedures,
- allergy testing, and
- hearing tests by an audiologist, but only if a Physician finds or suspects a disease or injury and refers the Member for testing.

E. Physician's Services

The following are covered Physician services:

- office visits for diagnosis and treatment of an illness or injury,
- surgery done on an inpatient or outpatient basis,
- care associated with an emergency medical condition (see above for definition of an emergency medical condition),
- Medically Necessary injections,
- consultations ordered by the attending Physician of a Member who is hospitalized,
- visits from an attending Physician while a Member is hospitalized, and
- immunizations, well child care, and routine preventative exams (physicals).

F. Maternity and Family Planning Services

1. Prenatal, delivery, newborn, and post-partum care.

- routine obstetrical care, including prenatal and postnatal medical visits,
- hospital and birthing center services,
- delivery services,
- inpatient nursery and Physician services,
- Medically Necessary care due to complication of pregnancy,
- Caesarean section, and
- services associated with a miscarriage or an elective termination of pregnancy.

VERY IMPORTANT NOTICE

Under the Health Insurance Portability and Accountability Act of 1996, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a 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). Vermont health coverage guidelines require the availability of certain services to all maternal-newborn dyads

for six weeks following delivery. These services include follow-up on discharge instructions (e.g. newborn feeding, cord care and recognition of signs of common newborn problems) and lactation training. Services may be provided by phone, by home visits or in a Provider's office. If a newborn is discharged at less than 24 hours of age, an examination of the newborn within 48 hours of birth is strongly recommended. If an examination does not occur, phone contact is highly recommended and an assessment made regarding the need and timing of future care. (For further information, see Bulletin 114 (Revised), Maternity Stays Guideline of the Vermont Department of Banking, Insurance, Securities and Health Care Administration).

While this Plan requires notification of the Plan of pregnancy in advance of an admission, a provider does not need to obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable). If a Member's length of stay will exceed the above periods, the Plan Administrator must be contacted. The Plan may not provide benefits for a length of stay in excess of the above periods unless the stay has been approved prior to the end of the above periods.

2. Infertility Services

Benefits are payable for the services listed below in conjunction with either in-vitro or in-vivo fertilization:

- diagnostic work-up and evaluation,
- ongoing drug therapy,
- laboratory studies, including ultrasound,
- surgery to extract and/or fertilize mature eggs (inpatient or outpatient),
- Gamete Intrafallopian Transfer (GIFT),
- Zygote Intrafallopian Transfer (ZIFT),
- counseling, and
- drugs administered or provided by a Participating Provider.

Donor related services or specimens or any experimental or investigational infertility procedures or therapies are excluded. No benefits are payable for infertility services rendered to a surrogate and/or surrogate fees.

Note: This Benefit has a Limited Lifetime Maximum Benefit for Eligible Expenses. See the Schedules of Benefits for this limit. A separate Limited Lifetime Maximum Benefits applies to drug costs associated with infertility services when the drugs are obtained through or reimbursed by the Pharmacy Benefit Manager. In addition, infertility services are not covered in obtained out-of-network in the Point-of Service Plan.

3. Other

- vasectomies and tubal ligations.

Note: Reversals of sterilizations are not covered.

G. Gynecological Care

All plan options provide for a routine preventive gynecological examination for Members each calendar year. In addition, other Medically Necessary gynecological care is covered subject to Deductibles, Copayments and Maximum Benefits as specified elsewhere in this document. In Point-of-Service plan options, Benefits are provided for two visits per calendar year to a network gynecological health care provider for reproductive or gynecological care, as well as visits relating to follow-up care for problems identified during such visits. All such visits are subject to Utilization Management review and the gynecological care Provider must furnish all relevant and necessary medical information to the Primary Care Provider for the Member's ongoing care. Benefits for these visits are payable at the in-network Benefit levels subject to Utilization Management review, Deductibles, Copayments and Maximum Benefits.

H. Acupuncture

The plan covers acupuncture performed by a license Physician (Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Naturopathic Doctor (ND), or licensed Acupuncturist

I. Home Health Care

Home Health Care services are covered as long as the following requirements are met. The services must be for Acute Care and provided in the Member's place of residence or other approved setting. The Member's Physician must certify and the Plan Administrator must agree that:

- the services cannot be provided on an outpatient basis in a doctor's office or at a hospital (i.e., the Member is homebound),
- the services are for Acute Care, not Chronic Care, and
- if the Member did not receive these services, he/she would be admitted to a hospital or skilled nursing facility.

The Member's Physician must re-certify care every 60 days or as otherwise required by the Plan Administrator or designee, however, no more frequently than every 60 days.

Home Health Care services include:

- skilled nursing services for part-time care by a registered nurse or licensed practical nurse (includes training of family members or other caregivers),
- home health aide services when the Member is also receiving nursing services from a registered nurse or licensed practical nurse or receiving physical or occupational therapy services, and
- physical, occupational, or speech therapy (subject to the Annual Maximum Benefits or limitations for short term rehabilitative therapy).

Home Health Care services **do not include:**

- Chronic Care,
- homemaker services,
- dietician services,
- maintenance therapy unless approved under a plan of care,

- custodial care, and
- food or home delivered meals.

J. Hospice Care

Hospice care is a coordinated plan for palliative and supportive care at home or in a special facility for patients who are terminally ill. The Plan provides care to meet the physical, psychological, spiritual, and social needs of dying persons and their families during the final stages of a terminal illness and during bereavement. To qualify:

- a Physician must certify that the patient is terminally ill and he/she has no more than a six-month life expectancy,
- the agency providing hospice care must be certified by Medicare or licensed in the state in which the hospice is located (in Vermont, operated by a home health agency which is certified by Medicare also qualifies a hospice provider for this Benefit),
- a primary caregiver must be available in the home, and
- both the patient and Physician must consent to the hospice care plan.

A professional team made up of trained personnel, homemakers, and counselors provides care. The team helps the family cope with the physical, psychological, spiritual, social, and economic stresses. Covered charges include:

- part-time or intermittent nursing care by or under the supervision of a registered nurse,
- part-time or intermittent services of other health care professionals who are reimbursable under this Plan (e.g., physical therapists, speech therapists, or occupational therapists),
- Physician services,
- services of a psychologist, social worker, family counselor, or ordained minister for individual and family counseling.
- laboratory tests,
- bed, board, services and supplies in a hospice facility, and
- reasonable homemaker services for cooking, cleaning, etc., provided by a homemaker who is part of the professional team of providers described above.

Hospice Benefits are not provided for:

- services provided by relatives by blood or marriage, or charges by a person who lives in the household of the terminally ill Member,
- charges by individuals who do not regularly charge for their services.
- periods during which the terminally ill Member is under the care of a Physician,
- curative or life-prolonging procedures, and
- services or supplies that are primarily to aid the terminally ill Member and other household members in daily living, apart from the reasonable homemaker services for cooking, cleaning, etc., provided by the homemaker who is part of the professional team of providers described above.

Note: Hospice is provided to Members who do not want the condition for which they are terminally ill treated and thus medical services and drugs to the terminally ill condition are typically palliative in nature. Benefits are not provided to treat the terminally ill condition when a

Member is in hospice. However, if a Member decides to withdraw from hospice, Benefits will once again be payable for the treatment of the illness for which the Member was placed in hospice.

K. Ambulance Services

Air or ground ambulance transportation when:

- transportation from the scene of an accident or the scene of a medical emergency to the closest facility that can provide the Medically Necessary services required, and
- transportation from home/to home or between medical facilities when Medically Necessary and ordered by a Physician.

L. Autism Spectrum Disorder

The Plan covers Medically necessary services related to Autism Spectrum Disorder (ASD), which includes Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder (CDD) and Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS)

You must get Prior Approval for services or your benefits will not be Covered. There is no age limitation for services related to ASD, CDD and PDD.

General Exclusions also apply.

M. Chronic and Short Term Rehabilitative Therapy

Medically Necessary short-term rehabilitative therapy will be covered when provided in an outpatient or home setting. However, Medically Necessary short-term rehabilitative therapy services that cannot be provided in an outpatient or home setting but must be provided in an inpatient setting will be covered up to 60 visits per plan year. Services may be subject to limits specified elsewhere in this document or its attachments.

Benefits for physical, occupational and speech therapy and chiropractic care are provided only if the therapy is performed by a licensed or certified Physical, Occupational or Speech Therapist or Chiropractor (if a state requires licensure for a profession, certification is not sufficient). In addition, providers may be required to submit a treatment plan after a specified number of visits whether they are treating POS or PPO Members. The treatment plan must be approved before additional visits will be considered for payment.

Benefits will not be provided for therapy services as part of chronic pain control, developmental, or other forms of rehabilitative services.

Covered outpatient physical, occupational, speech, and chiropractic care are limited to a combined amount of 60 visits per plan year as described below:

1. Physical Therapy

Therapy to relieve pain of an acute condition, restore function, or prevent disability following disease or injury.

2. Occupational Therapy

Therapy to promote the restoration of a covered person's ability to perform the ordinary tasks of daily living or the requirements of his or her job.

3. Speech Therapy

Therapy to correct swallowing defects and speech impairment caused by an accident, illness, or surgical procedure.

4. Chiropractic Care

Medically Necessary physiotherapy modalities and rehabilitative exercises for the restoration or motion, reduction in pain, and improvement in function.

Benefits are payable for office, home or residential treatment facility visits and include diagnostic x-rays of the spine. No other services billed by a chiropractor will be covered. Non-covered services include but are not limited to:

- operative or cutting procedures,
- surgical treatment of fractures, dislocations, or other accidental injuries,
- obstetrical procedures (includes prenatal adjustments),
- prescriptions or administration of drugs (includes over-the-counter drugs, vitamins, supplements, homeopathic preparations, etc.),
- laboratory tests,
- ultrasound tests, acupuncture, colonics, Transcutaneous Electrical Nerve Stimulation; and
- treatment of any visceral condition arising from problems or dysfunctions of the abdomen or thoracic organs.

5. Cardiac Rehabilitation

This benefit covers cardiac rehabilitation after a heart attack (myocardial infarction), a cardiac procedure (by-pass, angioplasty, etc.), or after being diagnosed with coronary artery disease. Covered services include:

- nursing services,
- physical therapy,
- education, and
- up to three supervised cardiac rehabilitation exercise sessions per week for up to 12 weeks.

Cardiac Rehabilitation services may require prior authorization from the Plan Administrator.

N. Other Therapy Services

In addition to the therapy Benefits described above, Benefits are payable for:

- radiation therapy (e.g., radium, radioactive isotope therapy, etc.),
- chemotherapy,
- infusion therapy, and
- dialysis treatment.

O. Home Infusion Therapy

Benefits are provided for the following services and supplies delivered in a Member's home:

- chemotherapy,

- intravenous antibiotic therapy,
- total parenteral nutrition,]
- enteral nutrients through a feeding tube,
- hydration therapy,
- intravenous/subcutaneous pain management,
- therapy of hemophilia or hypogammaglobulinemia, and
- other infusion-related Medically Necessary therapies.

In addition, Benefits are provided for the following services and supplies associated with home infusion services:

- solutions and pharmaceutical additives,
- pharmacy compounding and dispensing services,
- Durable Medical Equipment,
- ancillary medical supplies, and
- nursing services including patient and/or caregiver training, monitoring of intravenous therapy regimen, and skilled nursing care.

Benefits are only provided if a Physician prescribes a home infusion therapy regimen or prior approval is obtained.

No Benefits are payable for nursing services to provide or administer therapy that a patient or a caregiver is typically trained to administer. Some services (e.g., pharmacy supplies and Durable Medical Equipment) may be subject to limitations specified elsewhere in this Plan Document.

P. Prescription Drugs

The following information pertains to the pharmacy benefit. This information does not apply to drugs acquired while inpatient in a hospital, as those drugs are covered by medical or mental health and substance abuse coverage.

1. Managed Pharmacy Benefit

For plan options with a managed pharmacy benefit, Members must purchase their prescription drugs at a network pharmacy or the network mail order pharmacy. Initial prescriptions obtained from either a mail order or a retail pharmacy are limited to a 30-day supply of medication. The mail order prescription drug program is designed to be used for long-term maintenance medications that are taken for at least 90 days at a time. Effective April 1, 2004, after the 30-day initial fill, a 90-day refill supply may be obtained from either a network retail pharmacy or a network mail order pharmacy.

If a brand name drug is ordered when a chemical generic equivalent is available, the prescription will be filled with the generic drug. If a Member or a provider requests the prescription be filled with a brand drug when a generic drug is available and medical information sufficient to justify dispensing of a brand drug is not presented to the pharmacy benefit manager, the entire difference in cost between the brand name drug and the generic drug as well as any applicable deductibles and copays must be paid by the Member. Any amount payable by the Plan will be based on the cost of the generic drug.

For a limited number of drugs, prior authorization is required.

Routinely self-administered injectable prescription medications are covered under the pharmacy benefit. Injectable medication that is routinely injected in a provider's office or a clinical setting is covered by the medical portion of the Plan.

Except for prescriptions filled outside the U.S., no out-of-network pharmacy benefit is available. If a Member obtains a prescription from a non-network retail or mail order pharmacy in the U.S., she/he is responsible for 100% of the charges. Any claim submitted to the Plan Administrator for out-of-network pharmacy services will not be paid. Reimbursement may be obtained for prescriptions obtained outside the U.S. only if the drug is approved by the U.S. FDA or if it is an equivalent of an FDA approved drug as determined by the Pharmacy Benefit Manager. Details on the submission of a claim are available from the Employee Benefits Division.

Covered items include insulin and diabetic supplies. Items that are not covered include a limited number of prescription drugs, over the counter vitamins, minerals, food supplements and other items that do not require a prescription by law. Prenatal vitamins and mono-vitamins at concentrations not available over-the-counter are covered.

The managed pharmacy benefit coordinates coverage with 1) Medicare when Medicare is the primary payer for a prescription, 2) the Veteran's Administration, and 3) other health plans.

Any new drug that is introduced to the market will be reviewed in accordance with the PBM benefit guidelines agreed to between the PBM and the State and in conjunction with input from a PBM panel of pharmacists and Physicians, when needed, to determine coverage for the new drug. Likewise, any drug for which concerns have been raised regarding safety or effectiveness may be reviewed by the PBM to determine whether the drug will remain available to Members. A State of Vermont Preferred Drug List which is a list of covered prescription drugs is available the Employee Benefits webpage. A paper copy of the list may be obtained by contacting the Benefits Division. In addition, Employees will be provided with a State of Vermont Preferred Drug List on an annual basis prior to the Annual Open Enrollment.

Effective January 1, 2006, the prescription drug benefit for the TotalChoice, HealthGuard PPO and SelectCare POS is changed to implement the following. There shall be an initial deductible of twenty-five dollars (\$25) per patient for each year. As is currently the case, the State may select the Pharmacy Benefits Manager, who shall implement the terms of this section in accordance with its contract with the State. The Pharmacy Benefits Manager shall, in accordance with industry standards, categorize (and may subsequently re-categorize) prescription drugs into three tiers: generic, preferred brand and non-preferred brand. There shall be a co-payment by the patient on each prescription of ten percent (10%) for generic drugs, twenty percent (20%) for preferred brands, and forty percent (40%) for non-preferred brands. If there is no effective generic or preferred alternative to it, the co-payment for non-preferred brands shall be twenty percent (20%). There shall be a maximum out of pocket by the member, in addition to the deductible, of four hundred seventy-five dollars (\$475) in 2006 and six hundred dollars (\$600) in 2007. Effective January 1, 2010: (1) the member's maximum out-of-pocket expense is increased to \$750 in addition to the \$25 annual deductible; and (2) co-

payments made for non-preferred brand drugs shall not be counted toward the maximum out of pocket limit. There shall be no maximum out-of-pocket limit for co-payments made for non-preferred brands, except that the maximum out-of-pocket expense shall apply to all co-payments made for Specialty drugs.

The Pharmacy Benefit Manager shall, prior to implementing the list, and annually thereafter, provide a proposed list of the division of drugs into tiers prior to the implementation of such drug list. The parties will meet, review and discuss the drug list promptly. The parties must consider each other's positions in good faith. During any year the Pharmacy Benefits Manager may bring forward revisions for discussion and review in accordance with this paragraph. If VSEA contends that the list or revision finally implemented by the State violates this agreement, the VSEA retains all rights to contest this action.

2. Plan Options without a Managed Pharmacy Benefit

Members with a plan option that does not have a managed pharmacy benefit may obtain their prescriptions from any pharmacy, retail or mail order. Members pay for their prescription at the time of dispensing and submit a claim to the Plan Administrator. Out-of-pocket expenses will be minimized by taking generic drugs when possible and obtaining long-term medications from a mail order pharmacy.

Q. Durable Medical Equipment

Benefits are paid for most Medically Necessary supplies and for the rental and/or purchase of Durable Medical Equipment which is:

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

Examples of Durable Medical Equipment include wheelchairs, hospital-type beds, walkers, traction equipment, ventilators and oxygen equipment.

Durable Medical Equipment does not include such items as air conditioners, bathroom equipment, dehumidifiers, whirlpool baths, exercise equipment and other equipment that has both non-medical and medical uses, even if deemed Medically Necessary.

Durable Medical Equipment costing more than \$250 may require prior authorization from the Plan Administrator.

R. Prosthetic Devices

Coverage is available for the purchase, fitting, necessary adjustments, repairs and replacements of prosthetic devices and supplies prescribed by a Physician that replace"

- all or a portion of an absent body part (e.g., artificial limb),
- the lens of an eye, or
- all or part of the function of a permanently inoperative or malfunctioning body part.

However, external prostheses will be replaced only when replacement is due to growth or pathological changes of the affected site or due to wear and tear of the prostheses that renders it unable to perform the functions for which it was designed.

Benefits are also available for prosthetic devices which are attached to or inserted into prosthetic shoes, and which replace a missing, inoperative, absent or malfunctioning body part.

Cochlear implants are covered based on Medical Necessity, including hearing loss parameters and adult and child age-specific criteria.

The Plan will provide benefits for a single wig, toupee or hairpiece per calendar year, if required to replace hair lost as a result of chemotherapy or alopecia.

The Plan will provide benefits for post-mastectomy prostheses as required under the Women's Health and Cancer Rights Act.

Coverage is not available under this benefit for hearing aids, dentures and eyeglasses.

Prosthetic Devices costing more than \$250 may require prior authorization from the Plan Administrator.

S. Orthotics

When ordered by a Physician or a podiatrist, Benefits are provided for rigid or semi-rigid support devices that restrict or eliminate the motion of a weak or diseased body part. Examples include:

- splints,
- air casts, and
- carpal tunnel devices.

Benefits are only paid for:

- corrective shoes that attached to a brace, and
- shoe inserts that required to be custom made.

T. Vision Care Benefits

The following **routine** vision care services are payable under the Plan:

- one vision examination, including a routine refraction, every 24 months, and
- one pair of lenses every 24 months, but only if a new or changed prescription makes it necessary to buy new lenses.

The maximum Vision Care Benefit payment every 24-month period for vision exams and lenses combined is \$100. However, Pediatric vision benefits are covered up to age 21 with no dollar limits.

The Member must use an ophthalmologist, an optometrist, or an optician for these services. If a Member visits an optometrist for other than a routine eye exam, the optometrist's bill is paid under

the regular medical Benefits, not the vision care benefit. Lenses to replace the lens of the eye are also covered under the medical benefit. Pediatric vision benefits are covered up to age 21.

The Vision Care Benefit does not cover:

- sunglasses,
- frames,
- repair of lenses or frames,
- replacement lenses when no prescription change is necessary, or
- cosmetic extras, such as tinting or coating of lenses.

U. Dental Services Covered by the Medical Plan

Most dental procedures are covered under the Vermont State Employee Dental Assistance Plan. However, the following dental services, if Medically Necessary, are covered.

Diagnosis and treatment, to include surgical and nonsurgical procedures, for a musculoskeletal disorder that affects any bone or joint in the face, neck, or head that is the result of accident, trauma, congenital defect, development defect or pathology, including temporomandibular joint syndrome. This care can be prescribed or administered by a Physician or dentist.

- Care for an accidental injury to the jaw, natural teeth, mouth or face while a Member of the plan. (For the purposes of this coverage, an accident does not include any injury caused by biting or chewing while eating.)
- Oral surgery to correct a gross deformity resulting from major disease or surgery performed under this coverage.

Limitations

Benefits are provided for oral surgery or care made necessary by an accident or injury for up to six months following the accident or injury and include mandibular orthopedic repositioning appliances if Medically Necessary. Appliances, services, supplies or procedures to change the height of teeth or otherwise correct an occlusion (e.g., braces) are not covered.

Dental Service Covered under the Dental Plan Performed in a Hospital

If it is Medically Necessary for a Member to have certain dental work covered by the Dental Plan done in a hospital (outpatient or inpatient), the hospital charges, to include those for anesthesia services, are payable under this Plan. Oral surgery fees, to include anesthesia administered by the dentist, are not covered under this Plan. (If an anesthesiologist administers the anesthesia, the anesthesiologist's charges would be covered under this Plan, not the dental program.)

V. Transplant Procedures and Benefits

Transplants are covered only with prior approval. Members must notify the Plan Administrator as soon as possible after learning they may need a transplant. Hospital and provider charges are covered at 100% if the transplant is performed at a facility designated by the Plan Administrator. No deductible applies to such transplants. If a transplant is obtained at an in-network facility not designated by the Plan Administrator, hospital and provider charges will be covered as for non-transplant care, to include the payment of a deductible, coinsurance and copayments, if applicable.

The only transplants allowed in a participating facility that is not designated by the Plan Administrator are cornea, kidney and autologous bone marrow/stem cell transplants. No benefit is available for transplants performed in a non-network facility. All transplant requests will be reviewed based on:

- the patient's medical condition,
- the qualifications of the Physician's performing the transplant procedure, and
- the qualifications of the facility hosting the transplant procedure.

Covered services include the recipient's medical, surgical, and hospital services and inpatient immunosuppressive medications.

Special Transplant Benefits described below are provided only for the following transplants performed in a facility designated by the Plan Administrator or a network facility and approved by the Plan Administrator

- heart
- heart/lung
- lung
- liver
- pancreas
- kidney/pancreas
- small bowel/liver
- bone marrow/stem cell (allogeneic or autologous)
- kidney
- cornea

1. Special Transplant Benefits

For the above listed transplants, special Benefits are provided, including certain donor-covered expenses. The Plan covers the related transplant expenses up to the maximum stated (less of a Benefit is provided if incurred expenses are less than the amount specified).

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Organ procurement costs shall consist of: surgery necessary for organ removal, organ transportation, and when a live donor is involved, travel expenses (see below), hospitalization and surgery of the live donor with the exceptions as outlined below. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

Members who receive a transplant other than a cornea, kidney or autologous bone marrow/stem cell transplant at a facility designated by the Plan Administrator are also entitled to reimbursement for travel expenses up to a maximum of \$10,000 (limited to \$200 per day in lodging and meals). The travel benefit is not subject to any deductible and is available for the following pre-approved services: evaluation, candidacy, transplant and post-transplant care.

Travel expenses will be reimbursed for the person receiving the transplant and one companion who accompanies the recipient (a companion may be a spouse, dependent, family member,

legal guardian or any other person actively involved as the recipient's caregiver). Reimbursable expenses include charges for:

- transportation to, from and around the transplant site (including charges for a rental car used during a period of care at the transplant facility),
- lodging while at, or traveling to and from, the transplant site, and
- food and meals purchased while at, or traveling to and from, the transplant site.

By way of example, but not of limitation, travel expenses will not include any charges for:

- travel costs incurred due to travel within 60 miles of home,
- laundry bills,
- telephone bills,
- alcohol or tobacco products, or
- transportation charges in excess of coach class rates.

Travel benefits are only available if a Member is a potential candidate for or the recipient of an organ or tissue transplant. No travel benefits are available to Members who are donors under the Member's coverage.

2. Transplant Coverage Specifics

Effective January 1, 2002, benefits for transplants are as follow:

- If the recipient of an organ and the donor are both covered under the Plan, each person will receive benefits under his or her own plan option. Services to the donor will be charged against his or her plan option.
- If a Member is the recipient and the donor is not covered under the Plan, both the recipient and the donor will received benefits and they will all be charged to the recipient's Benefit maximum. Benefits will be paid to the donor only if Benefits remain under the Plan after the recipient's Eligible Expenses are paid according to Plan guidelines.
- No Benefits are available if a Member is a donor and the recipient is not covered under the Plan.
- No Benefits are available for the price of an organ if the organ is sold rather than donated.

W. Mental Health and Substance Abuse Benefits

1. Managed Mental Health and Substance Abuse Care

The following information applies to all plan options that have a managed mental health and substance abuse care benefit which is managed by a Managed Behavioral Health Organization (MBHO). Members have the choice of using a managed care network for services or a Provider outside the network. If the managed care network is selected, Benefits are paid at 100% for Medically Necessary services and there are no predetermined limits. Out-of-network services are subject to out-of-network deductibles if the Member has a Deductible for out-of-network Benefits that has not been met, coinsurance as outlined in the Schedule of Benefits, and limits on cost and utilization as specified in the Schedule of Benefits. Deductible amounts incurred for out-of-network mental health and substance abuse care are applied to the annual out-of-

network Deductible for all care. Coinsurance amounts, if any, for out-of-network mental health and substance abuse care are not applied toward the annual coinsurance maximum.

a. Inpatient Services. All in-network and out-of-network inpatient services, except emergency admissions, must be pre-approved by the MBHO. Inpatient services include inpatient stays, partial hospitalizations, residential treatment facility stays, and intensive outpatient programs. Inpatient services that are not pre-approved may not be reimbursed. The mental health and substance abuse healthcare manager must be notified of emergency admissions within 48 hours of the admission or as soon as reasonably possible.

b. Outpatient Services. Outpatient services, including in-network and out of network services, services do not require precertification or prior authorization. However, intensive outpatient program services do require prior authorization.

2. Unmanaged Mental Health and Substance Abuse Care.

Members in a PPO plan that does not offer a managed mental health and substance abuse care option may seek mental health or substance abuse care from any Provider who may be reimbursed under this Plan. However, use of Participating providers will minimize expenses as these providers cannot bill for the difference between their charges and the Reasonable and Customary Charges established by the Plan Administrator or designee. All inpatient services, whether or not they are from a facility contracted with the Plan Administrator (Participating Provider), must be approved by the Plan Administrator or designee. In the event of an emergency admission, the Plan Administrator or designee should be notified within 48 hours of the admission or as soon as reasonably possible. Failure to obtain approval for inpatient care may result in the denial of payment.

3. Covered Services

Covered mental health and substance abuse care services include, but are not limited to, psychological or psychiatric treatment of the following conditions:

- alcohol and substance dependence and/or abuse,
- anxiety disorders/stress,
- adjustment disorders,
- depression and manic depressive conditions,
- eating disorders,
- family and marital problems, and
- the diagnosis and treatment of Autism Spectrum Disorder, as defined in Act 127 of Vermont Statutes. Coverage shall be in accordance with the provisions of Act 127. Coverage begins at 18 months of age and does not have an age limitation. There shall be no visit limit for treatment of this disorder. Coinsurance, copayment, deductible, and cost-sharing requirements shall be the same as for coverage of any other physical or mental health problem.

Exclusions under the mental health and substance abuse portion of the Plan include, but are not limited to, treatment of the below listed conditions:

- Organic Mental Disorders. Changes in behavior induced by trauma to the brain or structural, chemical or metabolic changes in the brain. (Dementia resulting from early onset of Alzheimer's disease is an organic mental disorder. However, behavioral management of the early onset of Alzheimer's is covered under mental health Benefits when requested by a Mental Health Professional. This would include medication management of psychotropic medication, early stage individual therapy to manage depression and anxiety symptoms, family education, and behavioral management and neuropsychological testing for the purpose of a rule-out diagnosis.)
- Intellectual Disability except for acute brief interventions.
- Developmental and learning disabilities.

X. Second and Third Opinions

A Member who has been given a recommendation for elective surgery may ask for a second surgical opinion from a Physician who is qualified to treat the diagnosis, injury or sickness for which surgery has been recommended.

If the second opinion differs from the initial recommendation and the disagreement cannot be resolved by discussion between the two Physicians who rendered opinions, a third opinion from another Physician qualified to render an opinion may be sought.

Effective August 17, 2005, second opinions sought by Members for elective surgery are covered at 100%, with no deductibles or Cost Shares. A second opinion is not a covered service if: 1) the opinion is requested for cosmetic or dental surgical procedures not covered by the Plan. Third opinions sought by a Member are subject to deductibles and Cost Shares.

Y. Post-Mastectomy Services and Supplies

Under the Women's Health and Cancer Rights Act of 1998, Benefits are provided for breast reconstruction following a mastectomy, to include reconstruction of a breast on which a mastectomy was not performed in order to produce a symmetrical appearance. Coverage of prostheses and treatment of physical complications of a mastectomy, to include post-surgery lymphedemas, is also provided.

Z. Growth Cell Stimulating Factor

This Plan provides benefits for Medically Necessary growth cell stimulating factor injections taken as part of a prescribed, and approved if applicable, chemotherapy regimen. (8 V.S.A. § 8079e)

AA. Cancer Treatment

As required by State of Vermont law (8 V.S.A. § 4088b and Reg. H-2001-04), this Plan covers Eligible Expenses incurred as the result of Routine Patient Care Services provided to Members who participate in Approved Cancer Clinical Trials conducted under the auspices of the Vermont Cancer Center at Fletcher Allen Health Care, the Norris Cotton Cancer Center at Dartmouth-Hitchcock

Medical Center, a National Institutes of Health (NIH) facility or approved clinical trials administered by a Vermont Hospital or its affiliated, qualified Vermont cancer providers as long as the Routine Patient Care Services provided are not inconsistent with the terms of this Plan. For the purposes of this paragraph only, Routine Patient Care Services means Medically Necessary services that are provided in conjunction with an Approved Cancer Clinical Trial and include Physician services, diagnostic and laboratory tests, inpatient care and other services provided during the course of treatment in an Approved Cancer Clinical Trial for the condition which qualifies a Member for inclusion in an Approved Cancer Clinical Trial or for a complication of the treatment provided during the trial which is consistent with the standard of care for that condition or complication and would be covered even if the patient were not enrolled in an Approved Cancer Clinical Trial. Routine patient care services do not include:

- the costs of investigational new drugs not approved for market for any indication by the FDA or the cost of any drug being studied under an FDA-approved investigational new drug exemption for the purpose of expanding the drug's labeled indications,
- the costs of non-health care services that may be required as a result of the treatment being provided for the purposes of the approved cancer clinical trial,
- the costs of services that are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis and performed specifically to meet the requirements of the Approved Cancer Clinical Trial,
- the costs of any tests or services performed specifically to meet the needs of the approved cancer clinical trial protocol,
- the costs of running the Approved Cancer Clinical Trial and collection and analyzing data,
- the costs associated with managing the research associated with the approved clinical trial,
- costs for non-investigational treatments or services that would not otherwise be covered under the patient's health benefit plan, or
- any product or service paid for or supplied by the trial sponsor.

AB. Wigs

The Plan will provide benefits per calendar year for a single wig, toupee, or hairpiece if it is required to replace hair lost as a result of chemotherapy or alopecia.

X. HOW TO USE THE PLAN

Access to the above covered services and supplies is dependent on the plan option selected. To maximize benefits, Members need to be aware of and follow the requirements of the plan options provided below. In addition, regardless of which plan option is selected, Members should be aware of the participation status of any potential Provider.

A. Participating and Nonparticipating Providers

Providers are referred to as either "Participating" or "Nonparticipating" depending on whether or not a provider has signed an agreement with the Plan Administrator or designee.

Participating Providers agree to provide services and supplies for a specified rate. When a Member uses the services of a Participating Provider, except with respect to any applicable Deductible, the Member is responsible for paying only the applicable Coinsurance or Copayment for any Medically Necessary services or supplies. The Participating Provider generally deals directly with the Plan for any additional amount due. Collectively, Participating Providers form a network. Thus, Participating Providers are often referred to as “In-Network” Providers and health plans identify Benefits payable for services delivered by Participating Providers as “In-Network” Benefits.

Nonparticipating Providers do not have an agreement with the Plan Administrator or designee and are generally free to set their own charges for the services or supplies they provide. The Eligible Expense for any Medically Necessary services or supplies furnished by a Nonparticipating Provider will be based on a percentile of Reasonable and Customary (R&C) Charges and reimbursement to the provider will be subject to Deductibles, Coinsurance, Copayments, Annual or Lifetime Maximums and Exclusions. See the definitions section of this document for more information about the calculation of R&C Charges and the designated percentile of R&C. Due to Nonparticipating Providers not having an agreement with the Plan Administrator, Members may be billed by a Nonparticipating Provider and/or the Plan may reimburse the Member directly. Nonparticipating Providers may bill a Plan Member for any balance remaining after Plan payment. In addition, some Nonparticipating Providers may require payment prior to the rendering of services. These providers are often referred to as “Out-of-Network” providers and health plans identify benefits payable for services delivered by Nonparticipating Providers as “Out-of-Network” Benefits.

B. Point-of-Service (POS) Plans

If the plan selected is a POS plan, the Member and all of his/her Covered Dependents may select a provider from whom the Member and his/her dependents will obtain primary care. This provider is typically referred to as a Primary Care Provider or a Primary Care Physician (PCP). Primary care includes preventative care (e.g., physicals), care for most acute conditions and care for many injuries. PCPs, who include pediatricians, internists and family practitioners, also provide care for some chronic conditions (e.g., diabetes, asthma, heart disease), referring patients to specialists when indicated by a patient’s condition. Specialists usually report their findings to the PCP so the PCP is aware of all of the Member’s health conditions and treatments being received.

In a POS plan, most care should be coordinated through the Member’s PCP. If the PCP cannot provide the care needed or believes a consult from a specialist is appropriate, the PCP will refer the Member to another provider. The PCP will usually refer the Member to a Participating Provider and thus benefits are paid at the in-network level. However, if a Participating Provider is not available to render the desired services, the PCP may refer the Member to a Non-Participating Provider. A referral to a Non-Participating Provider must be approved by the Plan Administrator. Benefits paid for supplies and services rendered by a Non-Participating Provider which have been approved by the Plan Administrator or designee are paid at the “in-network” level even though the provider is a Non-Participating Provider.

While a referral is usually provided for one or a few visits which are expected to be made soon after the referral is given, a Member with a condition that requires ongoing care from a specialist may obtain, subject to Utilization Management review, a standing referral to a network specialist. A standing referral authorizes a series of visits or a specified time period for ongoing care from the network specialist and is provided in accordance to a treatment plan developed by the Member's PCP, the specialist, the Member and Utilization Management.

POS plans provide the option of seeking care from a Provider without a referral from a PCP. Mental Health and Substance Abuse services may also be obtained without a referral from a PCP. Additional information is provided in the Description of Covered Services and Supplies.

Note: A provider who participates with a POS plan might not participate with a PPO plan and vice versa.

C. Preferred Provider Organization (PPO) Plans

A PPO plan allows Members to obtain most care without prior authorization. However, the Member may be required to obtain prior authorization before seeking some types of care such as inpatient care in any type of facility or certain radiology procedures. Procedures that require prior authorization may change at the discretion of the Plan Administrator. Effective August 17, 2005, language contained in this Plan Document placing discretion on the Plan Administrator to change services or supplies requiring prior authorization shall not constitute a waiver by the VSEA to challenge said changes as a mandatory subject of bargaining. This language shall not be construed to constitute an admission by the State that such changes are subject to collective bargaining. The State shall notify the VSEA of any changes it intends to make to prior authorization requirements in the state health insurance plans before notifying plan members of such changes.

In addition, Members must contact the Plan Administrator or designee in other instances such as when she or he will seek inpatient mental health or substance abuse care.

A Preferred Provider Organization consists of individual Providers and groups of Providers who have agreements with the Plan Administrator or designee. This entity is also referred to as a network and the Providers in the network are called Participating Providers. The vast majority of Physicians in Vermont are PPO Participating Providers. A PPO plan option may have the same or different cost sharing rates for Participating Providers in the PPO network and Out-of-Network Providers. For example, one PPO plan option may pay 80% of Reasonable and Customary Charges for Eligible Medical Expenses regardless of whether a Provider is In-Network or Out-of-Network while another plan option may pay 80% of Reasonable and Customary Charges for Eligible Medical Expenses for In-Network Providers and 60% for Out-of-Network Providers. However, Out-of-Network Providers may charge more than Reasonable and Customary Charges and thus the Member would be responsible for not only the Cost Share but also the difference between Reasonable and Customary Charges and the Out-of-Network Provider's charges. In selecting a Provider, Members will minimize out-of-network expenses by selecting an In-Network Provider.

Note: A Provider who participates with a PPO plan might not participate with a POS plan and vice versa.

XI. UTILIZATION MANAGEMENT

A. Utilization Management Program Overview

To enable the Plan to provide coverage in a cost-effective manner, a Utilization Management (UM) program is provided for Members and POS in PPO plans. A Utilization Management program reviews the necessity, appropriateness and cost-effectiveness of proposed medical, surgical and mental health and substance abuse services to include hospital stays and inpatient stays in other facilities.

The recommendation, ordering, or provision of services, supplies or hospitalization by a provider does not guarantee a service, supply or hospitalization will be covered. UM personnel carefully review Provider referrals (if applicable), services and orders for Medical Necessity given a Member's condition.

B. Elements of Utilization Management

Utilization Management consists of four elements.

- 1. Prior Authorization Review:** Review of proposed health care services before the services are provided (also referred to as "pre-service Medical Necessity determination").
- 2. Continued Stay Review:** Ongoing assessment of the health care as it is being provided.
- 3. Retrospective Review:** Review of health care services after health care services have been provided.
- 4. Case Management:** A process whereby the Member, the Member's family, and health care Providers work together with Utilization Management personnel to coordinate a quality, timely, and cost-effective treatment plan. Case Management services are helpful for Members who require complex medical services as case managers guide them through the many choices of healthcare services, providers, and practices.

Each element is described in detail below.

1. Prior Authorization Review

a. How Prior Authorization Review Works

Prior authorization review is conducted to ensure a procedure, course of treatment or an admission is Medically Necessary. In the case of admissions, Prior Authorization Review may also result in an approved length of stay. The UM staff use established medical

standards to determine if recommended services meet or exceed accepted standards of care.

As a part of the prior authorization process for a surgical procedure, UM might request a second opinion if: 1) the effectiveness or reliability of the proposed procedure is questionable, 2) the proposed procedure involves a high risk relative to the anticipated benefit, or 3) there appear to be conflicting diagnoses, vague indications or potentially inadequate clinical management. The second opinion will be sought from a board-certified Physician who is independent of the Physician who initially recommended surgery and who is qualified to treat the diagnosis, sickness or injury that resulted in the initial recommendation for surgery. The provider from whom the second opinion is sought will not be eligible to perform the surgery should she or he also recommend surgery. However, if as a result of second opinion it is determined that the procedure recommended is not Medically Necessary, no Benefits will be paid if the Member chooses to undergo surgery.

A Member has the right to request a third opinion if the second opinion differs from the initial opinion and the disagreement between Physicians cannot be resolved.

Second opinions requested by UM are covered at 100% (Deductibles and Cost Shares are not applicable to UM requested opinions). All third opinions, whether requested by the Member or UM, are also covered at 100%.

b. What Services Must Have Prior Authorization (Approved Before They Are Provided)

• **TotalChoice Plan Option (effective August 17, 2006)**

TotalChoice members are responsible for prior authorization only with regard to inpatient admissions and services related to a potential transplant. Although prior authorization is not required for outpatient services, review for medical necessity can be done prior to services being rendered. If a prior authorization is not done prior to services being rendered, the claim will be reviewed for Medical Necessity when received by the claims office for payment. If the services are denied, the claim is denied to the member, who assumes liability for non-medically necessary services.

All inpatient admissions to any type of facility that are not emergency admissions must be prior-authorized. In the event of an emergency admission or childbirth, a Member may not be able to contact the Plan before being admitted. However, the Plan must be notified within 48 hours of an emergency admission, or as soon as reasonably possible. The Member, a family member, the admitting Physician, or the hospital may call the Plan.

• **All Other Plan Options**

All inpatient admissions to any type of facility that are not emergency admissions must be prior-authorized. In the event of an emergency admission or childbirth, a Member

may not be able to contact the Plan before being admitted. However, the Plan must be notified within 48 hours of an emergency admission and within 24 hours of a maternity admission, or as soon as reasonably possible. The Member, a family member, the admitting Physician or the hospital may call the Plan.

- **Services relate to a potential transplant**

- **Other services and supplies that may be required by a plan option**

The services and supplies for which a plan option may require prior authorization change as new services and supplies become available and as the use of established services and supplies become more common.

Effective August 17, 2005, language contained in this Plan Document placing discretion on the Plan Administrator to change services or supplies requiring prior authorization shall not constitute a waiver by the VSEA to challenge said changes as a mandatory subject of bargaining. This language shall not be construed to constitute an admission by the State that such changes are subject to collective bargaining. The State shall notify the VSEA of any changes it intends to make to prior authorization requirements in the state health insurance plans before notifying plan members of such changes.

Appropriate use of services and supplies is surveyed on a regular basis and Providers are furnished updated prior authorization lists from time to time. Outpatient procedures and studies, to include high cost radiological studies, whether performed in a Hospital, Provider's office or other location, often require prior authorization. In addition, women who will give childbirth should contact the Plan by the end of the third month of pregnancy to coordinate their admission and to learn of services available to pregnant Members. If a provider or a Member does not know if a service or supply requires prior authorization, the Plan Administrator should be contacted. See the section of this document entitled Plan Information, Addresses and Phone Numbers for contact information. (Please note: Point-of-Service options require several services and supplies to be prior authorized.)

c. How to Request Prior Authorization

Call the appropriate telephone number on your identification card. Please note that separate phone numbers may be used for mental health and substance abuse care services and medical services. The caller should be prepared to provide the following information:

- the Member's name, address, phone number and member number,
- the Provider's name, address and phone number,
- the name and location of any Hospital or facility that may provide care,
- the reason for the health care services or supplies, and
- the proposed date for performing the services or providing the supplies.

Additional information may be requested as part of the Prior Authorization process. Utilization Management personnel, including a registered nurse or a Physician or a Mental Health or Substance Abuse Professional, shall be available 24 hours a day to render Utilization Management determinations to Providers.

d. Failure to Request Prior Authorization

Failure to obtain prior authorization may result in no Benefits being provided for the supplies or services obtained, even if those services or supplies are listed as covered services or supplies in this document. In addition, the Plan may not provide any Benefits for complications arising from the provision of services or supplies which require prior authorization but for which prior authorization was not obtained. The Member or the Provider will have financial responsibility for services or supplies which require prior authorization but for which prior authorization was not obtained; however, effective August 17, 2005, the Member shall not bear financial responsibility for in-network charges in excess of the Member's cost-share if prior authorization had been obtained and the claim had been covered. This is because CIGNA Network Providers are prohibited from billing in excess of that amount if they, the Providers, provide services without obtaining prior authorization. For Out-of-network charges, the member may be responsible for the entire cost of services if prior authorization is not obtained; however, any Member who is charged for such Out-of-network care shall be allowed to submit a request for exception. Such requests must be provided to the Employee Benefits Division, which will review and investigate before forwarding them to the Plan Administrator. VSEA will be notified of any such requests within 15 days of receipt. In order to obtain an exception, the Member must demonstrate that his or her failure to ensure that prior authorization had been obtained was the result of an event or a series of events that could cause a reasonably prudent Member who was mindful of the need for prior authorization to believe that: prior authorization had been granted; or, that the Provider was handling the prior authorization and that it had been granted. An example of an instance in which a reasonably prudent Member would likely be granted an exception would be if a Member was being treated by an in-network provider who referred the Member for services to an Out-of-network provider without the out-of-network provider obtaining prior authorization, and the member was not made aware of their potential financial liability.

2. Continued Stay Review

a. How Continued Stay Review Works

When Members are receiving medical services in a hospital, Utilization Management (UM) personnel may contact their Physician to:

- assure continued stay as an inpatient is Medically Necessary, and
- help coordinate medical care with Benefits available under the Plan.

UM personnel may:

- advise providers of the various options and alternatives available under the Plan,
- assist with discharge planning, and
- help coordinate care following release from the hospital.

If an attending Physician recommends a stay should exceed the number of days authorized by UM prior to the admission, a request must be made for the additional days prior to the end of the certified length of stay previously issued by UM. Please note:

- not all services recommended or provided by a Provider may be considered Medically Necessary,
- certification of Medical Necessity does not mean that an Employee or their dependents are eligible for Plan Benefits or that Plan Benefits will be payable,
- Utilization Management personnel are not engaged in the practice of medicine and information obtained from UM is not intended to replace that which is provided by a Member's Provider; however, Plan Benefits may be affected by the determination of UM, and
- The State of Vermont, the Plan Administrator, and UM personnel are not responsible either for the quality of healthcare services provided or for the results if the patient chooses to forego receipt of healthcare services that have not been certified by UM as Medically Necessary.

3. Retrospective Review

All claims for services or supplies that were required to be reviewed under the Plan's Prior Authorization, Concurrent (Continued Stay) Review, or Second and Third Opinion Programs that have not been reviewed may be subject to retrospective review to determine if they were Medically Necessary. A service or supply found to not be Medically Necessary will not be paid by the Plan and will become the responsibility of the Provider or the Member.

If a determination is made that the services or supplies were not Medically Necessary, no Benefits will be provided by the Plan for those services or supplies. However, Members have the right to appeal this decision as outlined elsewhere in this document.

4. Case Management

a. How Case Management Works

Case Management is conducted by medical professionals who work with the patient, family, caregivers, health care providers, benefits personnel and Utilization Management personnel to coordinate a timely and cost-effective treatment program. Case management services

are particularly helpful when the patient needs complex and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Providers. Case Management personnel may also compare Plan Benefits to treatment suggested by a Provider and may suggest an alternate course of treatment that is medically appropriate when the treatment suggested by a Provider includes services or supplies that are not covered by the Plan.

Case Management services are provided at the discretion of the Plan Administrator and may be requested by a Member or a Member's representative (e.g., Provider, Spouse or parent). Effective August 17, 2005, members are encouraged, but not required, to utilize case management services, which can assist and guide them in the use of services and supplies that are medically necessary. Case management can help contain costs, benefiting the medical plan and the member.

b. Working with the Case Manager

Case Managers work directly with Providers, hospitals, and other facilities to review proposed treatment plans and to assist in coordinating services. Case Managers also contact patients and/or their families to assist in making plans for continued health care services and to assist in obtaining information to facilitate those services.

The Member, his/her family, or their Physician may call the Case Manager at any time to ask questions, make suggestions, or offer information.

Please note:

- not all services recommended or provided by a Provider may be considered Medically Necessary,
- certification of Medical Necessity does not mean that an Employee or their dependents are eligible for Plan Benefits or that Plan Benefits will be payable,
- Utilization Management personnel are not engaged in the practice of medicine and information obtained from UM is not intended to replace that which is provided by a Member's Provider; however, Plan Benefits may be affected by the determination of UM, and
- The State of Vermont, the Plan Administrator, and UM personnel are not responsible either for the quality of healthcare services provided or for the results if the patient chooses to forego receipt of healthcare services that have not been certified by Case Management as Medically Necessary.

C. Failure to Follow Required Utilization Management Provider

If a Member does not follow the Prior Authorization Review, Continued Stay Review, or Case Management procedures, or if the Member undergoes a medical procedure that has not been determined to be Medically Necessary as determined by a second or third opinion, the Plan

Administrator will refer the Member's claim for Benefits to UM for a retrospective review. If UM determines the services were not Medically Necessary, no Plan Benefits will be payable for those services. However, Members have the right to appeal this decision.

D. Eligibility, Payments, and Care Decisions

The Utilization Management program is not intended to validate eligibility for coverage or guarantee payment of Plan Benefits. Eligibility for and payment of Benefits are subject to the terms and conditions of the Plan as described in this document. For example, Benefits would not be payable if a Member's eligibility for coverage ended before the services were rendered.

The UM program is not intended to diagnose or treat medical conditions. All treatment decisions rest with the Member and Physician (or other health care Provider). The State of Vermont, the Plan Administrator and UM personnel are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services provided, even if they have been certified by UM as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified by UM as Medically Necessary. The Member should follow whatever course of treatment they and their Physician (or health care provider) believe to be the most appropriate. The Benefits payable by the Plan may, however, be affected by UM.

XII. APPROVALS AND APPEALS

A. Medical Approvals and Appeals

The following information is applicable to medical services. In addition, it is applicable to mental health and substance abuse services that have already been rendered or non-clinical mental health and substance abuse issues (e.g., amount payable for a service). For information regarding ongoing mental health or substance abuse care or future mental health or substance abuse care, see section B below.

1. Procedures regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the Plan. Medical necessity determinations are made on either a pre-service, concurrent, or post-service basis, as described below.

As noted elsewhere in this document, certain services require prior authorization in order to be covered. This prior authorization is called a "pre-service Medical Necessity determination." A Member or their authorized representative (typically a Provider) must request Medical Necessity determinations according to the procedures described below, elsewhere in this document and in the Provider's network participation documents as applicable.

When services or supplies are determined to be not Medically Necessary, the Member or his/her representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in this document, in the Provider's network participation documents and in the determination notices.

a. Pre-Service Medical Necessity Determinations

When a Member or his/her representative requests a Medical Necessity determination prior to care, the Plan Administrator will notify the Member or his/her representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Plan Administrator's control, the Plan Administrator will make notification within 15 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Member or his/her representative must provide the specified information to the Plan Administrator within 45 days after receiving the notice. Within 15 days of receipt of the specified information, the Plan Administrator will notify the Member or his/her representative of the determination. Failure to provide the specified information within the 45-day reply period will result in the rendering of a decision with the information available to the Plan Administrator.

If the determination periods above would (a) seriously jeopardize life, health, or the ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Member's health condition, cause severe pain which cannot be adequately managed without the requested services, the Plan Administrator will make the pre-service determination on an urgent basis. The Plan Administrator's Physician reviewer, in consultation with the treating Physician, will decide if an urgent determination is necessary. The Plan Administrator will notify the Member or his/her representative of an urgent determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Plan Administrator will notify the Member or his/her representative within 24 hours after receiving the request to specify what information is needed. The requested information must be provided to the Plan Administrator within 48 hours after receiving the notice. The Plan Administrator will notify the Member or his/her representative of the urgent benefit determination within 48 hours of receipt of the specified information. If the requested information is not provided within 48 hours, a benefit determination will be made with the information available to the Plan Administrator. Urgent determinations may be provided orally, followed within 3 days by written or electronic notification.

If a Member or his/her representative fails to follow the Plan Administrator's procedures for requesting a pre-service Medical Necessity determination, the Plan Administrator will notify the Member or his/her representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an urgent determination is required, as described above) after receiving the request. This notice may be provided orally, unless written notification was requested. Notice to a Member of their failure to follow pre-service determination procedures does not extend the response period.

b. Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved and an extension of treatment beyond that approved is desired, or, the Plan provides notice of a reduction in an approved course of treatment, the Member or his/her representative must request a concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. The Plan Administrator will notify the Member or his/her representative of the determination within 24 hours after receiving the request.

c. Post Service Medical Necessity Determinations

When a Medical Necessity determination is requested after services have been rendered, the Plan Administrator will notify the requester of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Plan Administrator's control, the Plan Administrator will make notification within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Member or his/her representative must provide the specified information to the Plan Administrator within 45 days after receiving the notice. Within 30 days of receipt of the specified information, the Plan Administrator will notify the Member or his/her representative of the determination. If the requested information is not provided within 45 days, a benefit determination will be made with the information available to the Plan Administrator.

2. Procedures Regarding Claim Payment Determinations

a. Post-Service Claim Determinations

When a Member or their representative requests payment for services which have been rendered, the Plan Administrator will provide notification of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Plan Administrator's control, the Plan Administrator will notify the Member and his/her representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Member and his/her representative must provide the specified information within 45 days after receiving the notice. Within 30 days of receipt of the specified information, the Plan Administrator will notify the Member or his/her representative of the determination. If the requested information is not provided within 45 days, a benefit determination will be made with the information available to the Plan Administrator.

b. Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination:

- the specific reason or reasons for the adverse determination,
- reference to specific plan information on which the determination is based,
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary,
- a description of the Plan's review procedures and the time limits applicable,
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit, and
- in the case of a claim involving urgent care, a description of the urgent review process applicable to such claim.

3. Complaints and Appeals

a. Start with Member Services

Members with a concern regarding a service, the quality of care, or Benefits can call the toll-free number on their ID card and explain their concerns to a Member Services representative. They can also express that concern in writing at the addresses that appears on the ID card, an explanation of benefits or a claim form.

The representative will attempt to resolve the matter on the initial contact. If more time is needed to review or investigate a concern, he/she will get back to the Member as soon as possible.

If a Member is not satisfied with a response regarding a coverage decision, the appeals procedure may be initiated.

b. Appeals Procedure

The Plan Administrator has a two-step appeals procedure for coverage decisions. To initiate an Appeal regarding coverage, submit a request for an Appeal in writing to the Plan Administrator at the address shown in the section of this document entitled "Plan Information, Addresses and Phone Numbers" within 180 days of receipt of a denial notice. To initiate an Appeal regarding eligibility, submit a request for an Appeal in writing to the Employee Benefits Division of the Department of Human Resources at the address shown in the section of this document entitled "Plan Information, Addresses and Phone Numbers." Members should state the reason they believe their Appeal should be approved and include any information supporting the Appeal, including any written comments, documents, records and other information relating to the Appeal. Members who are unable to write or choose not to write may contact a Member Services representative to register a coverage

Appeal by calling the toll-free number on their ID card. Members desiring to submit an eligibility Appeal may call the appeals coordinator in the Benefits Division.

Reasonable accommodations will be made to help a person with a disability participate in the appeal process. If English is not a Member's primary language the Plan Administrator will provide information about how to file an appeal and participate in the appeal process in the Member's primary language, upon the Member's request. Members may call or write to the Plan Administrator at the toll-free number or address on their Benefits ID card. The Plan Administrator will document the Appeal for the Member and provide copies of that documentation to the Member or the Member's representative.

For any Appeal related to an adverse benefit determination, should a reversal of that decision be made during any step in the appeals process, the Plan Administrator will promptly authorize or otherwise arrange for coverage of a Covered Service that was initially denied or restricted. Neither the Member nor the treating Provider will be liable for any services provided before notification to Member of the adverse determination and the final outcome of any appeal or independent external review. However, if a Member's treating Provider or his or her designee refuse or repeatedly fail to communicate with the Plan Administrator, when the opportunity to communicate has been offered in a time and manner convenient to them, the Member's treating Provider will be liable for any services provided. The Member will not be liable in either case. In the event of a final denial of a Member's claim, the Member must pay for services provided.

A Member will have reasonable access to, and may obtain copies of, all documents, records and other information relevant to his or her Appeal upon request and free of charge, within two (2) business days. In the case of a concurrent or urgent pre-service review, the Member will have access to or may obtain the materials immediately upon request.

c. Level One Appeal

The Appeal will be reviewed and the decision made by a representative not involved in the initial decision and who is not subordinate to any individual who was involved with the initial decision or other issue that is the subject of the Appeal. Appeals involving an adverse benefit determination that is based in whole or in part on a medical judgment will be considered by a health care professional who is a clinical peer of the Member's treating Provider.

- **Level One Urgent, Pre-Service Appeal**

Members may request an urgent consideration of their Appeal if: (a) the time frames under this process would seriously jeopardize their life, health or ability to regain maximum functionality, or, in the opinion of their Physician, would cause severe pain which cannot be managed without the requested services; or (b) the Appeal involves non-authorization of an admission or continuing inpatient hospital stay. The Plan Administrator's Physician reviewer, in consultation with the treating Physician, will decide if an urgent appeal is necessary. When an Appeal is urgent, the Plan Administrator will orally notify the Member and the Member's treating Provider (if known) with a decision as soon as possible based on the Member's medical condition but in no case later than seventy-two (72) hours after receipt of the Appeal. The Plan

Administrator will send written confirmation of the determination to the Member and Member's treating Provider (if known) within 24 hours of its oral notification to the Member.

Mental health/substance abuse and pharmacy benefit requests are generally considered urgent under Vermont regulatory requirements.

- **Level One Non-Urgent Pre-Service Appeal**

A written confirmation of the decision will be provided to the Member and the Member's treating provider (if known) in writing as soon as possible based on the Member's medical condition, but no later than thirty (30) calendar days after receipt of the Appeal.

- **Level One Concurrent Review Appeal**

For a Level One Appeal related to a request to continue or extend a course of treatment (i.e., a concurrent review), the Plan Administrator will orally notify the Member and the Member's treating Provider (if known) of its determination as soon as possible based on the Member's medical condition, but in no case later than 24 hours after the receipt of the Appeal. The Plan Administrator will send written confirmation of the decision to the Member and the Member's treating Provider (if known) within 24 hours of the oral notification.

- **Level One Post-Service Appeal**

The Plan Administrator will send a written confirmation of its determination to the Member and the Member's treating provider (if known), within a reasonable time period but not later than sixty (60) calendar days after receipt of the Appeal.

d. Level Two Appeal

If a Member is dissatisfied with the level one Appeal decision, within 90 days of receipt of the level one decision, he/she may request a second review. To initiate a level two Appeal, a Member follows the same process required for a level one Appeal. The Level Two Appeal will be done without deference to the initial adverse benefits determination or to the adverse determination of a Level One Appeal. Neither the Member nor Member's provider is responsible for any fees or costs associated with a Level Two Appeal. The Member will have reasonable access to, and may obtain copies of, all documents, records and other information relevant to the Appeal upon request and free of charge, within two business days of a request. In the case of concurrent or urgent pre-service reviews, the Member will have access to or may obtain the materials immediately upon request. Most requests for a second review will be conducted by the Appeals Committee, which consists of a minimum of three people. Anyone who is a member of the Committee may not: (a) have been involved in the initial adverse benefit determination or other issue that is the subject of the Appeal, (b) have been involved in the adverse determination of the Level One Appeal, or (c) be the subordinate of any person involved with the initial determination or other issue that is the subject of the Appeal. For Appeals involving Medical Necessity or clinical appropriateness, the committee may consult with at least one Physician in the same or similar specialty as

the care under consideration, as determined by the Plan Administrator's Physician reviewer.

The Member may request that the Plan Administrator identify any clinical expert whose advice was obtained in connection with the Member's adverse benefit determination, regardless of whether or not that expert's advice was relied on when the determination was made. Any clinical expert the Plan Administrator asks to consult regarding a Member's Level Two Appeal will not be the same clinical expert (if any) the Plan Administrator consulted with regarding the adverse benefit determination that is the subject of the Member's Appeal, or the subordinate of that clinical expert (if any).

For a Level Two Appeal, the Plan Administrator will acknowledge in writing that it has received the Member's request and schedule a Committee review. The Member will be consulted regarding setting the meeting date for the review. The Member or their representative may present his/her situation to the Committee in person or by conference call; however, participating in person or via telephone is not a requirement for the second level appeal meeting to proceed.

- **Level Two Urgent Pre-Service Appeal**

When an Appeal is urgent, the Plan Administrator will orally notify the Member and the Member's treating provider (if known) with a decision as soon as possible based on the Member's medical condition but in no case later than seventy-two (72) hours after receipt of the Appeal. The Plan Administrator will send written confirmation of the determination to the Member and Member's treating provider (if known) within 24 hours of its oral notification to the Member.

Mental health/substance abuse and pharmacy benefit requests are generally considered urgent under Vermont regulatory requirements.

- **Level Two Non-Urgent Pre-Service Appeal**

A written confirmation of the decision will be provided to the Member and the Member's treating provider (if known) in writing as soon as possible based on the Member's medical condition, but no later than thirty (30) calendar days after receipt of the Appeal.

- **Level Two Concurrent Review Appeal**

For a Level Two Appeal related to a request to continue or extend a course of treatment (i.e., a concurrent review), the Plan Administrator will orally notify the Member and the Member's treating provider (if known) of its determination as soon as possible based on the Member's medical condition, but in no case later than 24 hours after the receipt of the Appeal. The Plan Administrator will send written confirmation of the decision to the Member and the Member's treating provider (if known) within 24 hours of the oral notification.

- **Level Two Post-Service Appeal**

The Plan Administrator will send a written confirmation of its determination to the Member and the Member's treating provider (if known) within a reasonable time period, but not later than sixty (60) calendar days after receipt of the Appeal.

- **Level Two Appeal Not Related to an Adverse Benefit Determination**

For a voluntary Level Two Appeal not related to an adverse benefit determination, the Plan Administrator will send written notification to the Member within sixty (60) calendar days after receipt of the Appeal.

- e. **Notice of Benefit Determination on Appeal**

Every notice of a determination on Appeal will be provided in writing or electronically and, if an adverse determination, will include:

- the specific reason or reasons for the adverse determination,
- reference to the specific plan provisions on which the determination is based,
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other Relevant Information as define below,
- a statement describing any voluntary appeal procedures offered by the Plan, and
- notice that upon request and free of charge, a Member may receive a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding his/her appeal, and an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, experimental treatment, or other similar exclusion or limit.

- f. **Relevant Information**

Relevant Information is any document, record, or other information which:

- was relied upon in making the benefit determination,
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination,
- demonstrates compliance with the administrative processes and safeguards required by federal law [29 CFR part 2560.503-1 (b)(5)] in making the benefit determination, or
- constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

B. Mental Health and Substance Abuse Care and Appeals

The follow Appeal information is applicable to mental health and substance abuse care services, including ongoing services, future services, services that have already be rendered, or non-clinical mental health or substance abuse issues (e.g., amount payable for a service).

1. Submitting an Appeal

a. First Level Appeal

If the Plan Administrator has denied a Member's request to cover a health care service in whole or in part, the Member or someone in the Member names to act for them (an "authorized representative"), may request a first level Appeal, at no cost to the Member or the provider.

A first level Appeal must be requested no later than 180 days after a Member receives an initial denial notice. However, if a Member wishes to extend coverage for ongoing treatment of urgent care services ("urgent concurrent" services), without interruption beyond what the Plan Administrator has approved, the Member must request the review within 24 hours after receipt of the initial denial notice.

Requests for first level Appeals may be submitted to the Plan Administrator verbally or in writing. If a Member has a disability or English is not the primary language, the Plan Administrator will provide other ways for a Member to file an Appeal and take part in the Appeal process, at the Member's request. If a Member decides to seek a first level Appeal, the Member should contact the Plan Administrator at:

Blue Cross and Blue Shield of Vermont
First Level Appeals – MH/SA Appeals
PO Box 186
Montpelier, VT 05601-1086

Customer Service:(888) 778-5570

Assuming that the Member has provided all the information necessary to decide the Appeal, it will be decided within the timeframes shown below, base on the type of service that is the subject of the Appeal:

- Appeals related to "urgent concurrent" services (services that are part of an ongoing course of treatment involving urgent care and that have been approved by the Plan Administrator), will be decided within 24 hour of receipt,
- Appeals related to urgent services that have not yet been provided will be decided within 72 hours of receipt,
- Appeals related to non-urgent mental health and substance abuse services that have not yet been provided will be decided within 72 hours of receipt, unless an Appeal

qualifies for an exception to the expedited 72 hour timeframe, in which case it will be decided within 30 days of receipt. Appeals that qualify for an exception to the expedited 72 hour timeframe includes appeals that:

- were not treated as urgent within the initial review,
 - relate to treatment that can continue uninterrupted during non-expedited reviews,
 - relate to services scheduled far enough in the future so that non-expedited reviews can be completed before the scheduled date, or
 - the Plan Administrator believes it does not have to be expedited for medical reasons (and the Member and Member's provider agree)
- Appeals related to services that have already been provided will be decided within 60 days of receipt.

A Member must have completed a first level Appeal in order to pursue either a voluntary second level or an external Appeal process.

b. Voluntary Second Level Appeal

If a first level Appeal resulted in a denial, in whole or in part, a Member or Member's authorized representative may request a voluntary second level Appeal, at no cost to the Member or provider.

A voluntary second level Appeal must be requested no later than 90 days after receipt of a first level Appeal denial notice. However, if a Member wishes to extend coverage for ongoing treatment for urgent care services ("urgent concurrent" services, without interruption beyond what the Plan Administrator has approved, the Member must request the review within 24 hours of receipt of a first level Appeal denial notice. If you are filing a voluntary second-level appeal contact the Plan Administrator:

Blue Cross and Blue Shield of Vermont
Voluntary Second Level Appeals
PO Box 186
Montpelier, VT 05601-1086
Customer Service:(888) 778-5570

A Member's rights, who to contact and the timeframes for deciding voluntary second level Appeals are the same as those outlined above for first level Appeals. In addition, the Member and/or authorized representative have the opportunity to participate in a telephone meeting or an in-person meeting with the reviewer(s) for the second level Appeal, should they so wish. If the Member is unable to take part in the meeting in the way that has been offered, the Plan Administrator will provide another way. A Member may ask a treating provider(s) and any other persons the Member chooses to take part in the

meeting. If the scheduled meeting date does not work for the Member, the Member may request that the meeting be postponed and rescheduled.

Requesting a voluntary second level Appeal will have no effect on a Member's rights to any other benefits.

A Member has the right to have an Appeal denial reviewed by an independent external review organization. The independent external review program is administered by the Vermont Department of Financial Regulation. The external review process is more fully described in D. below.

C. Managed Prescription Drug Program Approvals and Appeals

1. Procedures Regarding Prior Authorization

Most prescribed medications will be dispensed without the need for authorization. However, a limited number of prescription drugs require prior authorization before being dispensed. Other drugs may be added from time-to-time. In addition, a brand drug will not be covered at the benefit level specified in the Schedules of Benefits when a generic equivalent is available unless the Member or a Physician provides information regarding the contraindication(s) of the generic drug. The Pharmacy Benefit Manager (PBM) shall, prior to implementing the prior authorization drug list, and annually thereafter, provide a proposed list of drugs requiring prior authorization, in accordance with industry standards, prior to the implementation of such list. The State and the VSEA will meet, review and discuss the proposed list promptly. The parties must consider each other's positions in good faith. During any year, the Pharmacy Benefits Manager may bring forward revisions for discussions and review in accordance with this paragraph. If the VSEA contends that the list or revision finally implemented by the State violates this agreement, the VSEA retains all rights to contest this action. The term "violates this agreement" and "this action" pertain solely to issues of (1) the parties obligations to meet, review and discuss; (2) the parties' obligations to consider each other's positions in good faith; and (3) disagreements regarding industry standards.

A prior authorization request may be made by the prescribing physician via phone, fax or letter. Responses to a phone-in prior authorization request are immediate. Fax requests and letters are generally handled within 72 hours of receipt of the request if all information necessary to make a decision has been provided to the PBM.

Prior authorization decisions are made by comparing authorization guidelines to information about a Member, to include their diagnosis, available to the Pharmacy Benefit Manager (PBM). The PBM does not make diagnoses, Medical Necessity decisions, or decisions regarding the appropriateness of a therapy, nor will it substitute its judgment for the judgment and responsibility of the Member's Physician. If a request is denied, the Member will be provided a specific reason for the denial.

2. Complaints and Appeals

Members who do not agree with the PBM's determination regarding a prior authorization request, the dispensing of a brand drug, the payment of a claim or any other drug benefit determination, may appeal the decision by calling the phone number on the pharmacy ID card or by writing to the address specified in the section of this document entitled "Plan Information, Addresses and Phone Numbers" within 180 days of the decision.

The pharmacy Benefit has a two-level appeal process. The first level of appeal is handled by the PBM. If a Member receives a determination on a prior authorization request with which he/she does not agree and submits an appeal, a decision will be rendered within 72 hours if all information necessary to make a decision has been provided to the PBM. If a Member pays for a prescription (either in whole or in part) and appeals the PBM's payment or lack thereof, he/she will usually receive a determination within 30 days.

If a Member does not agree with the PBM's decision regarding a Level One Appeal, he/she may initiate a Level Two Appeal within 90 days after receipt of a Level One Appeal denial notice. Detailed information regarding the Second Level Appeal process is provided to the Member by the PBM upon delivery of the First Level Appeal decision. The Second Level Appeal is performed by an independent review organization. As with the First Level Appeal process, decisions regarding urgent care Appeals are rendered within 72 hours of receipt of the information necessary to render a decision, decisions regarding non-urgent prior authorization requests are rendered within 15 days of receipt of necessary information, and decisions regarding payments made by the Plan are usually rendered within 30 days of receipt of the Appeal and the information necessary to render a decision. If information necessary to render a decision is not provided, a decision will be made with the information available to the independent review organization.

When pursuing an authorization or payment denial, a Member is entitled to receive any guidelines, rules or protocols relied upon in making the decision and all documents, records and other information relevant to the determination, without regard to whether this information was relied upon in making the determination.

D. State of Vermont External Appeal Process – Vermont Department of Financial Regulation

In addition to the appeals processes outlined above for medical care, mental health and substance abuse and prescription drugs, Members have additional appeal rights available under Vermont State law (Rule H-2011-02). Members can request an independent external review of an appealable

decision using the procedures described in the Rule. A Member must have exhausted the first level appeal process of the Plan. An appealable decision means an adverse benefit determination where the decision to deny coverage is based on one of the following reasons:

- the service was not medically necessary
- the Plan refused to allow the Member to see a Provider and the Member believes that decision is inconsistent with the Plan or any applicable laws and regulations,
- the service is determined by the Plan to be experimental or investigational, or
- a drug that was prescribed for a condition other than that approved by the Federal Drug Administration (FDA) (“off-label use”).

An independent external Appeal must be requested no later than 4 months or 120 days, whichever is longer, after a Member receives the First Level or Voluntary Second Level Appeal denial notice.

If a Member has an emergency and needs to request an external Appeal (and it cannot wait for normal business hours), they may call the External Appeals answering service at 888-236-5966. The call will be returned as soon as possible. This number is only for health insurance appeals. If the appeal is not an emergency or medically urgent, members should not use the emergency number.

For further information, Members may review Rule H2009-03 and Rule H-2011-02 of the State of Vermont Department of Financial Regulation, or they may contact the Department during business hours (7:45 a.m. to 4:30 p.m. EST, Monday through Friday). Call the Health Care Administration’s Consumer Services at 1-800-964-1784 or 802-828-3302.

XIII. EXCLUSIONS

The following medical conditions, services, supplies or expenses are not covered by the Plan. The Plan Administrator and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated have authority to initially determine the applicability of these exclusions and other terms of the Plan and to determine eligibility and entitlement to Plan Benefits, subject to all appeals processes. Decisions by these personnel may be appealed by Members. Any Member who is uncertain as to whether or not a medical condition, service, supply or expense is covered by the Plan should contact the Plan Administrator.

Cosmetic surgery/therapy. Cosmetic surgery or cosmetic therapy to improve or preserve physical appearance. However, the Plan will pay for reconstructive surgery when performed to correct a condition resulting from an accident, injury or illness incurred while covered under the Plans. This includes reconstructive surgery following a mastectomy to reconstruct a breast on which surgery has occurred or to reconstruct a breast on which surgery has not occurred to produce symmetry. The Plan will also pay for reconstructive surgery required as a result of congenital disease or anomaly in a child.

Hearing aids. The purchase, fitting, adjusting, servicing or repair of hearing aid devices, including but not limited to hearing aids and examinations for the purpose of prescription of such devices.

Dental. Treatment of the teeth or peridontum unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth; (b) charges made by a Hospital for bed and board or necessary services and supplies; or (c) charges made by a free-standing surgical facility or outpatient department of a Hospital in connection with surgery. For the purposes of this coverage by the Plan, an accident does not include any injury caused by biting or chewing while eating. Also excluded from coverage are expenses for dental prosthetics, dental services, or dental supplies of any kind, even if they are necessary because of symptoms, illnesses or injury affecting another part of the body; expenses for appliances (other than a mandibular orthopedic repositioning appliance) and services and procedures to change the height of teeth or otherwise restore occlusion.

Sterilization reversal. Charges for or in connection with procedures to reverse sterilization.

Prostheses, external, replacement. Replacement of an external prosthesis due to loss, theft or destruction. However, external prostheses will be replaced when replacement is due to growth or pathological changes of the affected site or due to wear and tear of the prostheses that renders it unable to perform the functions for which it was designed.

Weight Management.

- **Obesity.** Medical, surgical and other services intended primarily for the treatment or control of obesity which are not Medically Necessary including diet supplements, appetite suppressants, prescription drugs, diet centers, weight loss programs, dietary instructions, health clubs, exercise programs, gymnasiums, physical fitness programs and weight reduction procedures designed to restrict the ability to assimilate food such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass. Complications attributable to any such procedures are also not covered. Medically necessary Bariatric surgery and treatment for clinically severe obesity as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute is covered.
- **Underweight.** Expenses for medical or surgical treatment of severe underweight (more than 25% under normal body weight), including but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with Medically Necessary treatment of inherited metabolic disease, severe food allergies, anorexia, bulimia or acute starvation.

Ordered Services. Services for reports, evaluations, physical examinations or hospitalization ordered for employment, insurance, government licenses, forensic evaluations and custodial evaluations or court orders (unless Medically Necessary, ordered by a provider and is covered by this Plan).

Chronic Conditions. Therapy to improve general physical condition if not Medically Necessary, including, but not limited to, routine, long-term chiropractic care and other rehabilitative services. Therapy is also not covered when it does not: help restore or maintain a Member's health, prevent deterioration of a Member's condition, or, does not prevent the reasonably likely onset of a health problem. Benefits are not payable for chronic pain control and conditions related to learning disabilities or developmental delays (except to the extent required by law).

Consumable Medical Supplies. Consumable, non-prescription medical supplies, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as provided under "Description of Covered Supplies and Services."

Aids. Artificial aids including, but not limited to, corrective orthopedic shoes not attached to a brace, arch supports, commercially available shoe inserts, elastic stockings, dentures and wigs except as specified elsewhere in this document.

Job Related Injuries/Illnesses. Treatment of any job-related illness or injury for which a covered person has received or is entitled to receive, whether by settlement or by adjudication, any benefit under workers' compensation. All injuries or illnesses that may be covered under workers' compensation must be submitted to the workers' compensation plan before they will be considered for reimbursement under this Plan.

Government Facilities. Charges made by a hospital, facility or clinic owned or operated by or which provides care or performs services for the United States Government if such charges are directly related to a military-service-connected sickness or injury.

Illegal Services. To the extent that service rendered is unlawful where the person resides when the expenses are incurred.

No Cost Services. Charges for services or supplies for which a Member:

- is not obligated to pay, or
- is not billed, or
- would not have been billed except that they were covered under this policy, or
- would not legally have to pay if there was no coverage.

Excess Charges. To the extent charges are more than Reasonable and Customary Charges.

Custodial Services, Education or Training. Charges in connection with custodial care (regardless of where provided, including, but not limited to, adult day care, child day care, services of a homemaker, or personal care, except where Custodial Care is provided as part of a hospice program), rest homes, convalescent homes, homes for the aged, domiciliary care, institutional care for the physically or

mentally handicapped, education evaluation and education programs, therapy or training, supplies and equipment (including computers, software, books, aides, etc.) even if required because of injury, illness or disability (with exception of diabetes education), to include programs for the activities of daily living, instruction in scholastic skills such as reading and writing, or treatment for learning disabilities. However, outpatient self-management training and education for the treatment of diabetes, including nutritional therapy, is covered.

Government Provided Services. Services or supplies paid, or eligible for payment, directly or indirectly, by a local, state or federal government agency, except as otherwise provided by law. This exclusion applies whether or not a Member asserts his or her rights to obtain this coverage or payment for these services.

Infertility Donor Charges. Infertility donor charges and services whether or not the donor is covered by the Plan.

Eye care, select services. Eye exercises, visual training and surgical treatment for the correction of a refractive error, including radial keratotomy and Lasik surgery, when eyeglasses or contact lenses may be worn to provide corrected vision.

Not Medically Necessary. Charges for supplies, care, treatment or surgery which are not considered Medically Necessary for the care and treatment of an injury or sickness or that are not provided in accordance with accepted professional medical standards in the United States, as determined by the Plan. This includes counseling, immunizations, or vaccinations related to travel outside the United States.

Routine Foot Care. The following routine foot care is not covered:

- palliative or cosmetic foot care;
- treatment for bunions, metatarsalgia (pain and tenderness in the metatarsal region), flat feet, fallen arches, weak feet, chronic foot strain or subluxation of the feet other than an open cutting operation;
- orthotic shoe inserts, (unless required to be custom made);
- cutting or removal of corns, calluses and/or trimming of nails;
- application of skin creams; and
- other hygienic and preventative maintenance care.

In cases of circulatory or neurological disease involving the feet, such as arteriosclerosis or diabetic neuropathy, routine foot care, to include the treatment or removal of corns, calluses, bunions and toenails, is covered.

Speech Therapy, Select Services. Speech therapy services which:

- are used to improve speech skills that have not fully developed; or
- can be considered custodial or educational, or
- are intended to maintain speech communication, or
- are provided as part of chronic pain control

are not covered. Any speech therapy which is not restorative in nature or which is not provided by a licensed (or certified speech therapist where licensure is not required) will not be covered.

Relatives and Members of the Member's Household. Charges made by any covered provider who is a member of the Member's household or family (includes grandparents, parents, spouse, siblings, in-laws and children, by birth or marriage).

Experimental, investigational or unproven treatment methods. Experimental, investigational or unproven treatment methods including medical, surgical, diagnostic, psychiatric, substance abuse, or other health care technologies, supplies, treatment, procedures, drugs, drug therapies, devices or supplies are those which are not demonstrated through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed, and/or are not proven by Medical or Scientific Evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

Injuries due to war or military service. Illnesses or injuries, which are:

- a result of an act of war, declared or undeclared, for which treatment is provided by the government, or
- sustained during military service and the Department of Defense or the Veterans Administration has the responsibility to provide the service or care and the services of these government entities are reasonable available to the Member.

Foreign Care. Charges for medical care obtained while outside the United States or Canada, including hospital care, medical supplies, prescription drugs and provider services, when the primary purpose of being outside the United States or Canada was to obtain medical care, are excluded. Expenses for care incurred outside of the United States or Canada in a country in which a Member maintains a residence are covered at out-of-network Benefit levels. Care obtained outside the United States or Canada while traveling on business or for pleasure are also covered at the out-of-network Benefit levels.

Ancillary Services. Non-medical ancillary services, including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services,

training or educational therapy for learning disabilities, or developmental delays. (This exclusion does not apply to Autism Spectrum Disorder to the extent required by Vermont law.)

Failure to meet requirements of Primary Plan. Medical treatment when payment is denied by any Member's Primary Plan because treatment was received from a Non-Participating provider.

Prior Authorization Not Obtained. To the extent of the exclusions imposed by any pre-certification requirement shown in the Schedule of Benefits or this document.

Limitations and Maximums. Charges for services or supplies in excess of limitations or maximums set forth in this document.

Blood. The Plan does not pay for whole blood, blood plasma, packed blood cells or other blood products if these products are available to the providing facility without cost. However, benefits are provided for the administration, processing and storage of blood and its derivatives, to include autologous blood donations.

Convenience, personal service and comfort items and environmental modifications. Includes but is not limited to, air conditioners, humidifiers, physical fitness equipment, stair glides, elevators, lifts (to include those with track systems which mount to walls and ceilings), "barrier free" or other home modifications, health or fitness club fees, chairs with built-in lift mechanisms, shaped pillows, etc., even if prescribed by a Physician.

Cognitive retraining.

Charges more than two years old. Charges for covered services incurred more than two years prior to the date a claim is received from a Member or a Non-Participating Provider.

Inpatient charges if an inpatient on the effective date of coverage. If a Member is an inpatient on the date coverage becomes effective, coverage will be provided by the Plan if the Plan or the Plan's agent is the authorized utilization management authority, unless the Member has benefits under another plan that are extended. If a Member has benefits under another plan when coverage under this Plan becomes effective, this Plan shall be responsible upon discharge or when the benefits from the other plan expire, whichever comes first.

Drugs. Charges for prescription drugs excluded from the Plan or for drugs that do not require a prescription by Federal law. Drug exclusions are detailed in the Pharmacy Schedule of Benefits.

Private room. Accommodations for private room unless Medically Necessary.

Support therapies. Including, but not limited to, pastoral counseling (excluding hospice in which case pastoral counseling is covered), assertiveness training, dream therapy, music or art therapy, recreational therapy and smoking cessation therapy.

Phone calls. Telephone consultations between Providers and Members except within the first six weeks of discharge for childbirth if the child was discharged less than 24 hours from birth.

Transportation, non-ambulance. Expenses for and related to travel or transportation (including lodging, meals and related expenses) of a provider, Member (non-ambulance) or family member of a Member, even if prescribed by a Physician (except as specifically stated under the Organ Transplant coverage).

Non-medical charges. Charges from Providers for failure to keep a scheduled visit, completion of a claim form, photocopying, or discussing care with family members, caregivers, a health plan or health plan affiliate to include utilization management, disease management or case management personnel.

Nutritional counseling, formula and Medical food. Excluded are foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription), except when provided during hospitalization or for enteral nutrients through a feeding tube. Also excluded are expenses for nutritional counseling in the absence of an illness; for example, high calorie and/or high protein food supplements or other food or nutritional supplements are covered in conjunction with Medically Necessary treatment of inherited metabolic disease, severe food allergies, anorexia, bulimia or acute starvation. Nutritional evaluation and counseling are covered as medically necessary for the management of organic disease, including such conditions as diabetes, anorexia, Crohn's, hyperlipidemia, metabolic disorders, celiac disease and the like.

Massage Therapy. Massage therapy not performed by a licensed Physician, physical therapist or occupational therapist.

Intellectual Disability. Care for intellectual disability, except for acute, brief interventions when other diagnoses are present.

Home Health Care.

- Home health care services provided by someone who is related by blood, marriage, civil union or domestic partnership or who lives in the patient's home or when the patient is not under the continuing care of a Physician.
- Expenses for a homemaker, custodial care, childcare, adult care or personal care attendant except as provided under the Plan's hospice coverage.

- Any service that a family member who is not a licensed healthcare professional is typically trained to perform even if the service is Medically Necessary.

Customized equipment. Expenses for custom services, supplies, appliances or durable medical equipment (DME) when standard, non-customized services, supplies, appliances or DME are available and would provide a medically appropriate outcome.

Miscellaneous. Acupressure, Rolfing, Reiki, aromatherapy, naprapathy, stone therapy, hypnotherapy, homeopathy, self-help training and other therapies not specifically listed as covered.

Expenses for Which a Third Party is Responsible. Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party. See the Third Party Liability section of this document for an explanation of the circumstances under which the Plan will advance the payment of Benefits until it is determined that the third party is required to pay for those services or supplies.

Expenses Incurred Before or After Coverage. Expenses for services rendered or supplies provided: (a) before becoming covered under the Medical Plan; or (b) after the date a Member's coverage ends, except under those conditions described in the section of this document describing When Coverage Ends.

Illegal Occupation or Act. The Plan shall not be liable for any loss to which a contributing cause was a Member's commission of or attempt to commit a felony or to which a contributing cause was the Member's being engaged in an illegal occupation.

Duplicate Corrective Appliances. Including orthotic devices, prosthetic appliances, and Durable Medical Equipment.

Genetic services. Genetic testing that is not Medically Necessary is excluded from coverage. The following criteria will be used to help assess Medical Necessity:

- the Member displays clinical features, or the Member or their offspring would be at direct risk of inheriting the mutation in question (presymptomatic); and
- after history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain; and
- the result of the test will directly impact the treatment being delivered to the Member.

Midwife services. Services rendered by a midwife who is not a certified nurse midwife and licensed by the state in which they practice.

Hair Replacement Procedures, Medications and Devices. Expenses for hair transplantation and other procedures to replace lost hair or to promote the growth of hair, for the use of Propecia, or other prescription drugs or medicines used to promote the growth of hair, or for hair replacement devices including, but not limited to, wigs, toupees and/or hairpieces, except that the Plan will provide benefits for a single wig, toupee or hairpiece if it is required to replace hair lost as a result of chemotherapy or alopecia.

Transplantation (Organ and Tissue). Expenses for human organ and/or tissue transplants that are experimental and/or investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplantation, post operative services and drugs or medicines, and all complications thereof.

XIV. CLAIMS INFORMATION

A. Payment of Benefits in General

If services are provided through a Participating Provider, the Participating Provider will submit a claim directly to the Plan Administrator or designee who will pay the Provider. A Nonparticipating Provider may submit claims to the Plan Administrator or designee and may request a Member to sign a statement that assigns the benefit payment to the Provider. The Plan, at its discretion, may pay a Nonparticipating Provider directly or may pay the Member regardless of any assignment of Benefit statement. If a Member is paid for services rendered by a Nonparticipating Provider, he/she is responsible for reimbursing the Provider the amount paid and any of the difference between the billed charge and the amount paid. Nonparticipating Providers may require Members to pay for services before they are rendered. In such instance, Members must submit a claim form and any information required by the Plan Administrator to be reimbursed. Reimbursement will not be provided until the services have been rendered. Claim forms may be obtained from the Plan Administrator or from the Employee Benefits Division of the Department of Human Resources. If the Plan Administrator requests additional information to process a claim and the information is not provided within 90 days, the claim will be denied.

B. When a Member Must Repay Plan Benefits

If the Plan paid more than it should have because:

- some or all of the medical expenses were not payable by a Member, or
- a Member received money from a source other than the Plan which is legally liable for the payment of some or all of the incurred medical expenses, or
- a Member received any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party (the Plan maintains its full right to subrogation regardless of what portion or amount of a settlement is specified for the medical expenses for which Plan Benefits were paid), or
- the Plan erroneously paid Benefits to which a Member was not entitled under the terms and provisions of the Plan.

The Plan will be entitled to a refund from the Employee and his/her Provider, equal to the difference between the amount of Plan Benefits paid and the amount of Plan Benefits that should have been paid. For additional information on the procedures that may be followed by the Plan to recover these amounts, see the provisions regarding third party liability in a subsequent section of this document.

C. Time Limit For Filing Medical Claims

All claims must be submitted to the plan within two years from the date of service. No benefits shall be paid for any claim not submitted within this two-year period.

D. Limitation on When a Lawsuit May Be Started

Members may not start a lawsuit to obtain benefits until after they have exhausted all required levels of the appeal process. After exhausting all required levels of appeal, a Member may either initiated legal action or pursue any voluntary levels of Appeal, either internal or external to the Plan, as delineated in Section XII of this document. As per 8 V.S.A. ss4065(11), no lawsuit may be started more than 3 years after the time proof of claim must be given.

E. Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, and other Plan Fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan.

XV. DUPLICATE COVERAGE OF ELIGIBLE EXPENSES

This section describes the circumstances when a Member may be entitled to Benefits under this Plan and may also be entitled to recover all or part of a Member's Eligible Expenses from some other source(s). It also describes the rules that apply when this happens.

There are several circumstances that may result in a Member being reimbursed for medical expenses not only from this Plan, but also from some other source(s). This can occur if a Member is also covered by:

- another health care plan;
- Medicare or some other government program, such as Medicaid, CHAMPUS/TRICARE, a program of the U.S. Department of Veterans Affairs, or any coverage provided by a federal, state, or local government or agency, or any coverage required by federal, state, or local law, including, but not limited to, any motor vehicle no-fault coverage for medical expenses required by law; or
- workers' compensation.

Duplicate recovery of medical expenses can also occur if a third party is financially responsible for medical expenses because that third party caused the injury or illness giving rise to those expenses by a negligent or intentionally wrongful act.

This Plan operates under rules that prevent it from paying Benefits which, together with the benefits from any other source described above, would allow a Member or a Provider to recover more than 100% of medical expenses incurred. In many instances, a Member may recover less than 100% of those medical expenses from all sources of coverage and recovery. In some instances, this Plan will not provide coverage if a Member can recover from some other source. In other instances, this Plan will advance its Benefits, but only subject to its right to recover them if and when the Member recovers some or all of his/her losses from a third party.

A. Coordination of Benefits (COB): Coverage Under More Than One Group Health Plan

For purpose of this section, the “plan” refers to any group medical policy, contract or plan, whether insured or self-insurance, that provides benefits payable on account of medical services incurred by a Member or that provides medical services to a Member. A “group plan” provides its benefits to employees, retirees, or members of a group who are eligible for and have elected coverage. Many families have family members who are covered by more than one medical plan. If this is the case with an Employee’s family, the Employee must inform this Plan of all family coverage’s. Coordination of Benefits (COB) is a set of rules for the coordination of payments between plans. These rules identify the plan that will pay its benefits first, call the primary plan. The other plan, called the secondary plan, may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans (or any group plans) exceed 100% of the medical expenses incurred. Sometimes, the combined benefits that are paid will be less than the total expenses.

1. Which Plan Pays First: Order of Benefit Determination Rules

The Plan Administrator determines which plan pays first by applying order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. If a Member has another health plan and that plan does not have an established set of benefit determination rules it applies in a specific order, that health plan is designated as the primary payer. If the other health plan(s) has a set of benefit determination rules, the following rules shall be applied, in order, by the Plan Administrator.

- **Rule 1: Non-Dependent/Dependent**

The plan that covers a person as a subscriber (that is, other than as a dependent) pays first and the plan that covers the same person as a dependent pays second.

There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

- secondary to the plan covering the person as a dependent; and
- primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee).

Then the order of benefits is reversed, so that the plan covering the person as a dependent pays first and the plan covering the person other than as a dependent (that is, as a retired employee) pays second. (Example: Retired 67 year old spouse of an active state employee. Spouse has Medicare supplemental coverage through her former employer, G.E. Medicare is secondary to the State's coverage for the spouse, but primary to the G.E. plan. The State pays first, the G.E. plan pays second.)

- **Rule 2: Dependent Child Covered Under More Than One Plan**

The plan that covers the parent or partner whose birthday falls earlier in the calendar year pays first and the plan that covers the parent or partner whose birthday falls later in the calendar year pays second if:

- the parents are married to each other or are in a domestic partnership as defined by this Plan or are joined in a civil union or same sex marriage recognized by the State of Vermont;
- the parents are not legally separated (whether or not they have ever been married); or
- a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first and the plan that has covered the other parent for the shorter period of time pays second.

The word "birthday" refers only to the month and day in a calendar year, not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current

spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year in which any Benefits were paid or provided before the plan had knowledge of the specific terms of the court decree.

If the parents are not married to each other or are not in a domestic partnership (as defined by the Plan) through which coverage is provided to the child, or are not joined in a civil union or same sex marriage recognized by the State of Vermont, or are separated (whether or not they ever were married), or are divorced, or have had their civil union dissolved and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

- The plan of the custodial parent pays first;
- The plan of the Spouse or Partner of the custodial parent pays second;
- The plan of the non-custodial parent pays third; and
- The plan of the Spouse or Partner of the non-custodial parent pays last.

- **Rule 3: Active/Laid Off or Retired Employees**

The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

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.

If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

- **Rule 4: Continuation Coverage**

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

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.

If a person is covered other than a dependents (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state

law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than this rule.

- **Rule 5 Longer, Shorter Length of Coverage**

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

The start of a new plan does not include a change: (1) in the amount or scope of a plan's benefits; (2) in the entity that pays, provides or administers the plan; or (3) from one type of plan to another (such as from a single employer plan to a multiple employer plan).

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

- **Rule 6: The Final Fall-Back Rule**

If none of the preceding rules determines the primary plan, the Eligible Expenses shall be shared equally between plans.

2. How Much This Plan Pays When It Is Secondary

a. When Medicare is not the Primary Plan

When this Plan pays second, 1) it will pay no more than what it would have paid had it paid first, and 2) the payments from both plans shall not exceed the Eligible Expense. By example, consider an Eligible Expense of \$500. If this plan would have paid \$400, and the primary payer paid \$125, this Plan may pay up to \$375. ($\$125 + \$375 = \500, the Eligible Expense).

b. When Medicare is the Primary Plan

When this Plan pays secondary to Medicare, it will calculate what it would have paid using the amount allowed by Medicare as the Eligible Expense. It will then subtract what was paid by Medicare and pay up to the difference between what the Plan would have paid and what Medicare paid. The Plan maintains this Plan's Deductible, Coinsurance, and Exclusions. For example, if the Medicare allowable and thus the Plan Eligible Expense for a procedure is \$1,000 and the Plan would have paid 80% of the

allowable amount, or, \$800, then nothing will be paid by the Plan and the Member must pay \$200. The Plan maintained the Coinsurance of \$200. However, if Medicare had an exclusion that is not an exclusion under this Plan, this Plan will pay as the primary payer.

3. Administration of COB

- a.** To administer COB, the Plan reserves the right to: (i) exchange information with other plans involved in paying claims; (ii) require that Dependents or their Provider furnish any necessary information; (iii) reimburse any plan that made payments this Plan should have made; or (iv) recover any overpayment from a Provider, other insurance company, settlement, or Member.
- b.** If this Plan should have paid Benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be Benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.
- c.** To obtain all the Benefits available, Covered Dependents should file a claim with each plan that covers them for medical expenses incurred. However, any person who claims Benefits under this Plan must provide all the information the Plan needs to apply COB.
- d.** If this Plan is secondary, secondary medical benefits will only be made when the coordinating primary plan pays medical benefits and the medical expense is a covered expense under this Plan.
- e.** If this Plan is secondary, and if the coordinating primary plan provides benefits in the form of services, the reasonable cash value of each service will be taken into consideration as an Eligible Expense.
- f.** If this Plan is secondary, and if the coordinating primary plan does not cover healthcare services because they were obtained from a Provider who is not a Participating Provider with the other plan, this Plan will not pay Benefits. Providers who have opted not to participate with Medicare to pursue private contract payments are not considered Medicare Participating Providers. Benefits are not paid by Medicare for services and/or supplies received from such providers and this Plan will not pay as the secondary payer. When this Plan does pay Benefits as a second payer, it will only pay to the extent the Benefits would have been payable if this Plan were the primary plan.
- g.** If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan; and if an amount equal to the benefits this Plan would have paid had it been the primary plan is advanced, this Plan will be subrogated to all rights a Member may have against

the other plan, and the Member shall execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

B. MEDICARE AND OTHER GOVERNMENT RELATED PROGRAMS

1. Medicare

a. Medicare Eligible Participants Who Retain or Cancel Coverage Under This Plan

When an Employee retires from active employment and the Employee and/or any Covered Dependents become eligible for Medicare Part B, Medicare becomes the primary plan. This Plan will coordinate benefits as though the individual has enrolled in Medicare Part B, whether or not the individual enrolls in Medicare Part B. This plan will not pay premium penalties for an Employee's failure to enroll in Medicare in a timely manner. An Employee who retires on a disability retirement is responsible for enrolling in Medicare disability coverage in a timely manner upon being found eligible by the Social Security Administration.

If a Member becomes covered by Medicare because of end-stage renal disease (ESRD) or disability, the Plan Administrator should be notified.

If an Employee and any Covered Dependents are covered by this Plan and by Medicare, and the Employee is actively employed, this Plan will continue to provide the same Benefits and the Employee's contributions for coverage will remain the same, and this Plan pays first and Medicare pays second.

If an Employee cancels coverage under this Plan due to Medicare eligibility, coverage of the Employee's Covered Dependents will terminate, but they may be entitled to COBRA Continuation Coverage. See the subsequent section regarding COBRA coverage.

b. Coverage Under This Plan and Medicare When a Member Becomes Totally Disabled

If a Member becomes entitled to Medicare because of a disability, Medicare becomes the primary payer and this Plan pays second.

c. Coverage Under this Plan and Medicare When a Member Has End-Stage Renal Disease

If, while actively employed, an Employee of any Covered Dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of: (1) the month in which Medicare ESRD coverage begins; or (2) the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare is the primary payer and this Plan is the secondary payer.

2. Medicaid

If a Member is covered by both this Plan and Medicaid, this Plan is primary and Medicaid is secondary.

3. CHAMPUS/TRICARE

If a Member is covered by both this plan and CHAMPUS/TRICARE, this Plan is primary and CHAMPUS/TRICARE is secondary.

4. Veteran’s Affairs Facility Services

If a Member receives services in a U.S. Department of Veterans Affairs Hospital or facility for military service-related illness or injury, Benefits will not be paid under this Plan.

5. Motor Vehicle Coverage

If a Member is covered for medical benefits under any motor vehicle no-fault coverage required by law (includes Personal Injury Protection coverage), the motor vehicle no-fault coverage is primary and this Plan is secondary. If a Covered Individual is covered for medical benefits under a medical payments rider of a motor vehicle insurance policy, the motor vehicle coverage is primary.

6. Other Coverage Provided by State or Federal Law

If a Member is covered by both this Plan and other coverage provided by any other state or federal law, the coverage provided by any other state or federal law is primary and this Plan is secondary unless that coverage specifies it is not the primary payer when other coverage exists.

XVI. WORKERS’ COMPENSATION

This Plan does not provide Benefits if the medical expenses are covered by workers’ compensation or occupational disease law.

If the application of workers’ compensation law is contested for the illness or injury for which expenses are incurred, this Plan will pay Benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers’ compensation or occupational disease law. However, before such payment will be made, the Member must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or designee.

XVII. THIRD PARTY LIABILITY

A. Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party is required to pay because of a negligent or wrongful act, but it will advance payment (hereafter called an “Advance”),

subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee and/or Dependent if and when there is any recovery from any third party:

- even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical expenses for which the Advance was made;
- even if the recovery is not sufficient to make the employee or ill or injured person whole pursuant to state law or otherwise; and
- without any reduction for legal or other expenses incurred by any ill or injured person in connection with the recovery against the third party or that third party's insurer except to the extent reduction is mandated by law;
- except as may be expressly agreed to by the Plan at its sole discretion.

Members are required to notify the Plan Administrator of any expenses incurred due to the negligent or wrongful act of another party, to include Providers as may be the case in an instance of malpractice.

B. Reimbursement and/or Subrogation Agreement

The covered Employee and any ill or injured Covered Dependent on whose behalf the Advance is made must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the "Agreement") in a form provided by or on behalf of the Plan. If the ill or injured Covered Dependent is a minor, incapacitated, or incompetent to execute that Agreement, that person's parent (in the case of a minor) or spouse or legal representative (in the case of an adult) must execute that Agreement.

If the Agreement is not executed at the Plan's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights to be reimbursed from any recovery from any third party.

C. Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and the ill or injured Covered Dependent each agree that they:

- will reimburse the Plan from all amounts paid or payable to either of them by any third party or that third party's insurer for the entire amount Advanced; and
- do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights; and
- notify and consults with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party based on any alleged negligent or wrongful act that may have caused or contributed to the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and

- inform the Plan Administrator or designee of all material developments with respect to all claims actions, or proceedings they have against the third party.

D. Subrogation

By accepting an Advance, the Covered Employee and ill or injured Covered Dependent jointly agree that the Plan will be subrogated to their right of recovery from a third party or that third party's insurer for the entire amount Advanced. This means that, in any legal action against a third party who may have wrongfully caused the injury or illness that resulted in the Advance, the Plan may be substituted in place of the Covered Employee and/or ill or injured Covered Dependent, but only to the extent of the amount of the Advance.

Under its subrogation rights, the Plan Administrator may, at his or her discretion:

- start any legal action or administrative proceeding deemed necessary to protect the Plan's right to recover Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the Covered Employee and/or ill or injured Covered Dependent, but in doing so, Plan personnel will not represent, or provide legal representation for either of them with respect to their damages that exceed any Advance; or
- intervene in any claim, legal action, or administrative proceeding started by the covered Employee or Covered Dependent against any third party or third party's insurer on account of any alleged negligent or wrongful action that may have caused or contributed to the injury or illness that resulted in the Advance.

E. Remedies Available to the Plan

If the Covered Employee or ill or injured Covered Dependent does not reimburse the Plan as required under this provision, the Plan Administrator may, at his or her sole discretion:

- apply any future Plan Benefits that may become payable on behalf of the Employees and all Covered Dependent to the amount not reimbursed; or
- obtain a judgment against the Covered Employee and/or ill or injured Covered Dependent from a court for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the Covered Employee and/or ill or injured Covered Dependent.

XVIII. EXTENSION AND CONTINUATION OF BENEFITS COVERAGE

The Plan does not provide Plan Benefits for any medical expenses incurred after coverage ends. However, under certain circumstances:

- a Member's coverage may extended for certain expenses after coverage ends; and

- a Member's coverage may be continued.

This section explains when and how this extension and continuation of coverage occurs.

A. Extension of Coverage During Total Disability or Hospitalization

If coverage ends because of termination of employment, and if on the end of termination:

- a Member is Total Disabled (as defined in the Definitions section of this document), or hospitalized, and
- the disabled person or hospitalized person is not otherwise covered by Medicare or by any other group or individual health insurance policy or health care plan,

Benefits will be extended for the hospitalized or disabled person. In the case of disability, Benefits for the medical condition causing the Total Disability of the disabled person will be extended for the disabled person, subject to the terms and provision of this Plan, for up to 12 months after coverage ends, provided the disabled person continues to be Totally Disabled, unless the disabled person becomes covered by any other group or individual health care insurance policy or health care plan or by Medicare, in which case the extension of coverage will cease if that coverage provides benefits to the disabled individual.

In the case of hospitalization, Benefits for the hospitalized person will be extended, subject to the terms and provisions of this Plan, as long as the person remains hospitalized for the condition for which s/he was admitted or a complication of that condition, for the duration of the hospitalization or 52 weeks, whichever is less, unless the hospitalized person becomes covered by any group or individual health care insurance policy or health care plan or by Medicare, in which case the extension of coverage will cease if that coverage provides benefits to the hospitalized individual.

The Plan reserves the right to have a Member claiming Total Disability to be examined by a Physician selected by the Plan Administrator or designee at any time during the period that Benefits are extended under this provision. The cost of such an examination will be paid by the Plan.

The extension of coverage does not apply to the expenses of a child born as a result of pregnancy that exists when coverage terminates.

B. Continuation of Coverage

1. Death of an Employee or Retiree

Covered Dependents of a deceased retiree who did not retire due to a disability or who retired due to a disability prior to January 2, 1998 and who receives a monthly survivorship payment from the State may continue coverage indefinitely. Once such a Member discontinues coverage, they may not elect coverage under the Plan at a later date. Surviving Covered

Dependents of an Employee (active employee or retiree) who will not receive a monthly survivorship payment may continue coverage for 36 months under COBRA (see next paragraph).

2. COBRA Continuation of Coverage in General

In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA. This law generally requires that most employers with group health plans offer employees and their covered dependents the opportunity to temporarily continue their health care coverage at a rate no more than 102% of group rates when coverage under the plan with otherwise end. This plan is in compliance with Federal law regarding COBRA. A summary of the features of this law is provided below. If this document conflicts Federal law regarding COBRA, Federal law applies.

Members can continue coverage for a time if coverage ends from one of several reasons. COBRA does not apply to Partners or children of Partners unless they are considered legal dependents under the governing rules and regulations of the Internal Revenue Service.

a. Qualifying Events and Maximum Periods of Continuation of Coverage

Qualifying events and maximum periods of continuation of coverage are specified by federal law. In general, Employees who terminate for reasons other than gross misconduct are entitled to coverage for themselves and their Covered Dependents via COBRA for 18 months, dependents of deceased employees are entitled to coverage for 36 months, divorced spouses are entitled to coverage for 36 months and a Covered Child who ceases to maintain Eligible Dependent status (e.g., turns 26 years of age) is entitled to coverage for 36 months. Other qualifying events exist and the periods of continuation vary by event. Detailed information is available from the Plan Administrator.

b. When the Plan Must be Notified of a Qualifying Event

In order for a Covered Dependent to be entitled to continue coverage, the dependent must notify the Plan of:

- 1) The death of the employee;
- 2) The divorce or legal separation from the employee; or
- 3) The event under which a child loses Eligible Dependent status within 60 days after the event occurs. If the Plan does not received written notice of any such event with that 60-day period, the Covered Dependent will not be eligible for COBRA continuation coverage. This notification is also necessary so that the Plan Administrator may provide a Certificate of Creditable Coverage in the event COBRA Continuation Coverage is not elected.

c. Notice of Entitlement to COBRA Continuation Coverage

When:

- 1) employment terminates or hours are reduced so that an Employee is no longer entitled to coverage under the Plan, or
- 2) the Plan is notified on a timely basis that an Employee died, divorced, became legally separated or became entitled to Medicare or that an Eligible Dependent child lost Covered Dependent status,

the Employee or Covered Dependent(s) will be notified of the right to continue their healthcare coverage. They will then have 60 days to apply for COBRA continuation coverage. If the Employee or the Covered Dependents do not apply within that time, their healthcare coverage will end as of the date of the qualifying event.

d. Coverage Provided When COBRA Continuation Coverage is Elected

If a Member chooses COBRA Continuation Coverage, the Plan is required to provide coverage that is identical to the current coverage under the Plan that is provided for similarly situated Employees or Eligible Dependents.

If, during the period of COBRA Continuation Coverage, a covered person marries, has a newborn child, or has a child placed with him/her for adoption; that Spouse or Dependent Child may be enrolled for coverage for the balance of the period of COBRA Continuation Coverage on the same terms available to active Employees. Enrollment must occur no later than 30 days after the marriage, birth or placement for adoption. A child born or placed for adoption while on COBRA Continuation Coverage (but not a Spouse the former Employee marries while on COBRA Continuation Coverage) will have all the same COBRA rights as Eligible Dependents who were covered by the Plan before the event that resulted in loss of coverage. Adding an Eligible Dependent may cause an increase in the amount paid for COBRA Continuation Coverage.

If, during the period of COBRA Continuation Coverage, the Plan's benefits change for active employees, the same changes will apply to COBRA beneficiaries.

e. Changes to Maximum Period of COBRA Continuation Coverage

(1) Multiple Qualifying Events

If continuation coverage is for a maximum period of 18 months, and during that period, another qualifying event takes place that would otherwise entitle a Covered Dependent to a 36-month period of continuation coverage, the 18-month period will be extended for that individual. The total period of coverage for any Covered Dependent will never exceed 36 months from the date of the first qualifying event. For example, if an Employee terminated employment and elected COBRA continuation coverage for 18 months for him/herself and their Covered

Dependent(s), and died during that 18-month period, the continuation coverage for the Covered Dependent(s) could be extended for the balance of 36 months from the date employment terminated.

However, if an Employee becomes entitled to COBRA continuation coverage

because of termination of employment or reduction in hours worked that occurred less than 18 months after the date they became entitled to Medicare, their Covered Dependent(s) would be entitled to a 36-month period of COBRA continuation coverage beginning on the date the Employee became entitled to Medicare. For example, if termination of employment occurred less than 18 months after the date an Employee became entitled to Medicare, Covered Dependent(s) would be entitled to COBRA continuation coverage for a 36-month period beginning on the date the Employee became entitled to Medicare.

(2) Entitlement to Social Security Disability Income Benefits

If a Member is entitled to COBRA continuation coverage for an 18-month period, that period can be extended for the individual on COBRA who is determined to be entitled to Social Security disability income benefits, and for any other covered family members, for up to 11 additional months if all of the following conditions are satisfied:

- the disability occurred or before the start of COBRA Continuation Coverage, or within the first 60 days of COBRA Continuation Coverage; and
- the disabled covered individual receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration; and
- the Plan is notified of the determination (a) no later than 60 days after it was received from Social Security and (b) before the 18-month COBRA continuation period ends.

This extended period of COBRA Continuation Coverage will end at the earlier of the end of 29 months from the date of the qualifying event of the date the disabled individual becomes entitled to Medicare.

f. Cost for COBRA Continuation Coverage

Members pay 102% of the full cost of the coverage during the COBRA continuation period. The amount is payable monthly. There will be an initial grace period of 45 days to pay the first amount due starting with the date continuation coverage was elected. There will then be a grace period of 31 days to pay any subsequent amount due. If payment of the amount due is not received by the end of the applicable grace period, the COBRA continuation coverage will terminate as specified in Section VI.

g. Termination of COBRA Continuation Coverage

COBRA Continuation Coverage may be terminated if:

- the State of Vermont no longer provides any medical coverage to any of its similarly situated employees;
- the applicable premium for COBRA Continuation Coverage is not paid on time or within the grace period as specified in Section VI;
- the Covered Individual is or becomes entitled to Medicare; or
- the Covered Individual is or becomes covered under another group health plan that does not contain an exclusion or limitation that applies to any pre-existing condition of the Covered Individual.

h. Other Information about COBRA Continuation Coverage

If the coverage provided by the Plan is changed in any respect for active Plan participants, those changes will apply at the same time and in the same manner for everyone whose coverage is continued as required by COBRA. If any of those changes result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued as required by COBRA as of the effective date of those changes.

3. Continuation Coverage if not Eligible for COBRA

Vermont law (8 V.S.A. § 4090) requires employers with group health plans to offer employees and their Covered Dependents the opportunity to temporarily continue their healthcare coverage at group rates for up to eighteen months when coverage under the plan would end due to one of the following: (1) the Employee's loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage; (2) the divorce, dissolution or legal separation of the Covered Employee from the Employee's spouse or Civil Union partner; (3) a Dependent Child ceasing to qualify as a dependent child under the requirements of the plan; or (4) the death of the Employee or covered member.

To obtain continuation coverage under 8 V.S.A § 4090, a member must have been covered under the Plan on the date of the qualifying event. In the event of termination, the Employee must not have been terminated due to misconduct as defined in 21 V.S.A § 1344.

Upon a member's notification to the Plan Administrator of a qualifying event, notice of the right of continuation shall be provided to such member within thirty (30) days. A person electing continuation coverage shall notify the Plan Administrator in writing within sixty (60) days of the date the person receives notice of the right of continuation following the occurrence of the qualifying event. Notice of election to continue coverage shall be accompanied by the initial contribution which shall include payment for the period from the qualifying event through the

end of the month in which the election is made. The contribution is 100% of the published premium. Contributions shall be due on a monthly basis in advance. Coverage will terminate upon the occurrence of any of the following:

- the date eighteen months after the date coverage would have terminated due to the death or loss of employment of the Employee, the divorce, dissolution or legal separation of the Covered Employee from the Employee's spouse or Civil Union partner or a Dependent Child ceasing to be a Dependent Child;
- the Covered Dependent fails to make a monthly premium payment by the first day of the month for which coverage is desired (a grace period, as defined in Section VI of this document, shall apply); or timely payments of the required contribution, or
- the Covered Dependent is covered by Medicare, or
- the person becomes covered by any other group insured or uninsured arrangement that provides hospital and medical coverage for individuals in a group, under which the period was not covered immediately prior to the occurrence of a qualifying event, as defined by 8 V.S.A § 4009a(b), and no pre-existing conditions exclusion applies; provided, however, that the person shall remain eligible for continuation coverages which are not available under the insured or uninsured arrangement; or
- the date on which the group policy is terminated or, in the case of an employee, the date the decedent's or terminated employee's employer terminates participation under the group policy. If such coverage is replaced by similar coverage under another group policy:
 - (1) the person shall have the right to become covered under that replacement policy, for the balance of the period that he or she would have remained covered under the prior group policy;
 - (2) the minimum level of benefits to be provided by the replacement policy shall be the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy; and
 - (3) the prior group policy shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement has not occurred.

XIX.CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS

When coverage ends, a Certificate of Creditable Coverage will be provided for each former Member that indicates the period of time they were covered under the Plan. If, within 62 days after coverage under

this Plan ends, a former Member becomes eligible for coverage under another group health plan, or buys a health insurance policy, this certificate may be necessary to reduce any exclusion for pre-existing conditions that may apply. The certificate will indicate the period of time covered under this Plan, and certain additional information that is required by law.

The certificate will be sent by first class mail shortly after a Member's coverage under this Plan ends. If a Member elects COBRA Continuation Coverage, another certificate will be sent by first class mail shortly after the COBRA Continuation Coverage ends for any reason.

In addition, a certificate will be provided upon receipt of a request for such a certificate if that request is received by the Plan Administrator within two years after the later of the date coverage under this Plan ended or the date COBRA Continuation Coverage ended.

The provision of certificates is mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This plan is in compliance with Federal law regarding HIPAA. If this document conflicts Federal law regarding HIPAA, Federal law applies.

XX. PLAN ADMINISTRATION

A. Parties Responsible for Benefit Payments

The State of Vermont is liable for payment of medical and pharmacy Benefits according to provisions of this Plan. The Plan Administrators for these Benefits do not insure or otherwise guarantee Benefits. The State of Vermont purchases stop-loss coverage to reimburse the Plan for certain losses in excess of amounts specified in the stop-loss policy.

Mental health and substance abuse coverage is provided via an insurance policy. The insurer from whom the State of Vermont purchases mental health and substance abuse care coverage is responsible to pay Plan Benefits as specified in this document.

B. Parties Responsible for the Administration of the Plan

The Employee Benefits Division, Department of Human Resources, State of Vermont, is responsible for determining eligibility for the Plan and providing eligibility information to the parties who administer the Benefits of the Plan. The following parties are assigned Plan Administrator status for determining availability of Benefits under the Plan for Members.

Medical, Unmanaged Mental Health and Substance Abuse, and Unmanaged Pharmacy Benefits:	Blue Cross and Blue Shield
Managed Mental Health and Substance Abuse: Managed Pharmacy Benefits:	Blue Cross and Blue Shield Express Scripts, Inc. (initial determination/level one Appeals only)

C. Administration of Special Groups and Employee Groups Outside the Executive Branch

All rules stated herein related to coverage, administration of benefits and Appeals are applicable to every Plan Member. Any policies or procedures regarding eligibility of Special Groups and Employee Groups outside the Executive Branch which deviate from those specified in this document are subject to approval or rejection by the Commissioner of Human Resources at his/her sole discretion.

XXI. PLAN TERMS, AMENDMENTS, ASSOCIATED DOCUMENTS AND TERMINATION

The State of Vermont intends that the terms of this Plan described in this document, including those terms relating to coverage and Benefits, are legally enforceable, and that this Plan is maintained for the exclusive benefit of participants, as defined by law.

Subject to collective bargaining agreements set forth under Title 3 of the Vermont Statutes Annotated the State and the VSEA may terminate, amend or eliminate benefits in whole or in part under this Plan or under their collective bargaining agreements. Although it is the State of Vermont's intention to continue to maintain this Plan, in no manner should this Plan be interpreted as providing permanent or irrevocable benefits or type or level of benefits. All amendments to the Plan Document shall be made in writing.

In the event of any dispute over eligibility for coverage or availability of Benefits, the following associated documents may provide more specific information.

- Contract with Blue Cross and Blue Shield for administration of medical, unmanaged mental health and substance abuse, and unmanaged pharmacy Benefits.
- Contract with Blue Cross and Blue Shield for managed Mental Health and Substance Abuse insurance coverage.
- Contract with Blue Cross and Blue Shield for stoploss coverage.
- Contract with Express Scripts, Inc., and its associated documents for managed pharmacy benefit administration.
- Contract with MCMC, LLC., for second level managed pharmacy Benefit appeals.
- Labor agreements between the State of Vermont and the Vermont State Employees' Association, Inc.

XXII.PRACTICE OF MEDICINE

The Plan, Plan Administrator or any of his/her designees are not engaged in the practice of medicine. The diagnosis, treatment, care or lack thereof, or any health care services provided or delivered is decided by the Member, his/her guardian (if applicable) and his/her Providers. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused by any Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

XXIII. RELEASE OF INFORMATION

A. By Plan

The Plan will be compliant with Federal and State law regarding confidentiality. Any individually identifiable information collected by the Plan will be treated as confidential information, and will not be disclosed to anyone without a Member's written consent, except as:

1. required to administer the Plan or to process claims,
2. required to do quality audits (auditors will be required to be bound by confidentiality agreements),
3. required by law or regulation or in response to a duly issued subpoena, or
4. as reasonable required in the pursuit or defense of any claim action brought by or against the Plan or any contract Plan Administrator or insurer.

B. By Member

Members may be requested to furnish information to verify eligibility for coverage to support the payment of a claim. Information that may be requested includes, but is not limited to:

- change of name;
- change of address;
- Medicare enrollment or disenrollment;
- existence of other medical coverage;
- marriage, divorce, dissolution of civil union or domestic partnership or death of any Member;
- any information regarding the status of a Covered Child, including but not limited to 1) the child reaching the Plan's limiting age; or 2) information required to make an initial and ongoing determination of the incapacitation status of a child.

A Dependent Certification Form must be submitted annually to verify a Covered Dependent child's status. The Plan Administrator will send the Dependent Certification Form each year. Failure to return the Dependent Certification Form will result in a dependent child's coverage being cancelled.

To extend coverage for an incapacitated child beyond the age of 26, proof of the incapacitation must be submitted within 60 days before coverage would otherwise end.

If a Covered Dependent becomes ineligible for coverage, an Enrollment/Change application must be filed with the Benefits Division. Otherwise, an Employee may continue to pay for that dependent even though the coverage has ended. NO REFUNDS are allowed. Even if this change will not affect the type of coverage (i.e., two person or family), the information must be provided for enrollment purposes.

Failure to provide any information requested by the Plan Administrator or designee may result in Benefits not being provided by the Plan.

XXIV. HEADINGS THAT DO NOT MODIFY PLAN PROVISIONS

All headings in this Plan Document are included for the sole purpose of generally identifying the subject matter of the substantive text so that a table of contents and index can be constructed for the convenience of the reader. The headings are not part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

XXV. PLAN INFORMATION, ADDRESSES AND PHONE NUMBERS

HIPAA

For information regarding rights under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, contact:

HIPAA Coordinator

Employee Benefits Unit
Department of Human Resources
144 State Street
Montpelier, VT 05620-1701
(802) 828-3455

OR

Vermont Department of Financial Regulation

89 Main Street
Montpelier, VT 05620-3601
(800) 828-3302

MEDICAL BENEFITS

Customer Service and Claims

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

(888) 778-5570

Point of Service Appeals

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

Preferred Provider Organization Appeals

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

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

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

PHARMACY BENEFITS

Customer Service, Claims and Appeals (PPO and POS)

Express Scripts, Inc.
PO Box 390873
Bloomington, MN 55439-0873
(800) 550-8090

Note: Second level Appeals are decided by MCMC, LLC, but are sent to ESI, which, in turn provides MCMC, LLC, with the information presented at the first level Appeal.

XXVI. SEVERABILITY

Any determination that any provision(s) of this document or the application of any provision thereof to any person or circumstance is invalid, illegal or unenforceable shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this document in whole or in part.

XXVII. DEFINITIONS

Acute Care. Care that is intended to produce measurable improvement or maximum rehabilitative potential within a reasonable and medically predictable period of time.

Acute Condition. An illness or injury, marked by a sudden onset or abrupt change of health status that requires prompt medical attention. Care for an Acute Condition (Acute Care) may include hospitalization of limited duration.

Admission. Occurs when a patient who is admitted to a Hospital incurs a room and board charge at such Hospital.

Allowed Amount. The amount the Plan Administrator determines is Reasonable and Customary for services or supplies.

Ambulance. A specially designed and equipped vehicle, including a helicopter or airplane, for the emergency transportation of the sick and injured.

Ambulatory Surgical Care Facility. A facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures on an outpatient basis and which fully meets one of the following two tests:

1. It is licensed as an Ambulatory Surgical Center under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it is accredited by an accrediting body recognized by the Center for Medicare and Medicaid Services.

Annual Open Enrollment. The period specified by the Department of Human Resources via the labor agreement, or, as otherwise mutually agreed up by the Vermont State Employee Association, Inc. and the Department of Human Resources, during which employees may elect coverage, change Plan options and add Eligible Dependents to the Plan.

Appeal. An oral or written request made by or on behalf of a Member to the Plan Administrator which explicitly seeks reconsideration of a Plan decision regarding participation in the Plan or denial of reimbursement for, or coverage of, a service or supply the Plan determined was not Medically Necessary, was not a covered service or supply, or was not an Eligible Medical Expense.

Approved Cancer Clinical Trial. An organized, systematic, scientific study of therapies, tests, or other clinical interventions for purposes of treatment, palliation, or prevention of cancer in human beings. The trial must seek to answer a credible and specific medical or scientific question for the purpose of advancing cancer care and:

1. be conducted under the auspices of the Vermont Cancer Center at Fletcher Allen Health Care, the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center, National Institutes of Health (NIH) facilities or a Vermont Hospital or its affiliated, qualified Vermont cancer care providers;
2. be conducted by a facility and personnel capable of conducting such a trial by virtue of experience, training, and volume of patients treated to maintain expertise;
3. enroll only those patients for whom there is no clearly superior, non-investigational treatment alternative to the cancer clinical trial and the available clinical or preclinical data provide a reasonable expectation that the treatment obtained in the cancer clinical trial will be at least as effective as the non-investigational alternative;
4. be conducted only after obtaining fully informed, written consent from the patient or the patient's legally authorized representative in a manner that is consistent with current legal and ethical standards and requirements; and
5. be conducted under the auspices of a peer-reviewed protocol that has been approved by one of the following entities:
 - a. one of the National Institutes of Health (NIH);
 - b. an NIH-affiliated cooperative group that is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group;
 - c. the FDA in the form of an investigational new drug application or exemption; or
 - d. the federal departments of Veterans Affairs or Defense.

Behavioral Health Care. Care for mental health related conditions and substance abuse to include alcohol and drugs.

Benefit. The amount payable for a claim, based on Reasonable and Customary charges, after calculation of all deductibles, coinsurance, and copayments, and after determination of the Plan's exclusions, limitations and maximums.

Benefits Division. The Employee Benefits Division of the Department of Human Resources, State of Vermont.

Birthing Center. A health facility that provides a home-like setting under a controlled environment for the purpose of childbirth. It must be staffed, equipped and operated to provide: (a) prenatal care; (b) delivery; (c) post-partum and (d) newborn care for twenty-four hours after childbirth. It must be

licensed or approved by the authorized agencies of the jurisdiction in which it is located or it must be listed with the National Association of Childbearing Centers.

Case Management. A process in which healthcare professionals work with the patient, family, caregivers, and Providers to coordinate a timely and cost-effective treatment program. Case Management services are usually provided when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through the healthcare system.

Certificate of Creditable Coverage. A certificate provided upon termination from the Plan that documents the period of coverage under the Plan as required by Health Insurance Portability and Accountability Act of 1996. This certificate may reduce waiting periods a plan may impose on a former Member.

Chronic Care. Treatment of an illness, injury or condition that is:

1. not necessarily directed toward alleviation or prevention of an Acute Condition, and
2. of long duration without any reasonably predictable date of termination.

Chronic conditions may be marked by recurrences of conditions requiring Acute Care on a periodic basis.

Civil Union Partner. A person of the same sex as the Employee who is legally joined in civil union to the Employee.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986). A Federal act which grants employees, their dependents and certain others the right to continue receiving coverage under an employer's health plan(s) at a rate no higher than 102% of the group rate.

Coinsurance. The percentage of the Eligible Expense Members must pay after meeting their Deductible.

Copayment/Copay. A Cost Share which is typically a set dollar amount.

Cosmetic. Primarily intended to improve appearance.

Cost Share. The portion of an Eligible Expense for which Members are responsible.

Covered Child(ren). A Dependent Child who is enrolled in the Plan.

Covered Dependent. An Eligible Dependent who is enrolled in the Plan.

Covered Employee. An Eligible Employee, as described in Section II of this document, who has enrolled in the Plan.

Custodial Care. Primarily for maintenance or designed to help in a person's daily living activities. Custodial Care is not primarily provided for its curative value. Custodial Care includes:

1. help in walking, bathing, dressing and feeding,
2. preparation of special diets,
3. supervision over administration of medications, and
4. care not requiring skilled nursing services.

Date of Hire. The first completed full day of work as an employee, appointed official or elected official for a Special Group or the State of Vermont.

Deductible. The amount Members must pay toward the cost of services each calendar year before the Plan pays any benefits. Members may have a separate deductible for services received from Non-Participating or Out-of-Network Providers than from Participating or In-Network Providers.

Dependent Eligibility Date. The date a dependent becomes or became an Eligible Dependent.

Domestic Partner. A person of the same or opposite sex as the Employee who meets the following criteria:

1. the persons are each other's sole domestic partner and have been in an exclusive and enduring relationship sharing a residence for not less than six consecutive months prior to the submission of an application for coverage;
2. the persons are eighteen years or older;
3. neither person is married to anyone;
4. the parties are not related by blood closer than would bar marriage under Vermont state law;
5. the persons are competent to enter into a legally binding contract; and
6. the persons have agreed between themselves to be responsible for each other's welfare.

Persons who live together for economic reasons but have not made a commitment to an exclusive enduring domestic partnership as described above shall not be considered to be domestic partners.

Durable Medical Equipment. Equipment that: (1) can withstand repeated use; (2) is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; (3) is not disposable or non-durable; and (4) prescribed by a Physician. Durable Medical Equipment includes, but is not limited to, wheelchairs, hospital type beds, walkers, traction equipment, ventilators and oxygen equipment.

Elective Surgery. Any surgical procedure that is not performed under emergency circumstances.

Eligible Dependent. An Employee's:

- legally married, including same sex spouse, from whom the Employee is not legally separated;
- partner through civil union;

- Domestic Partner (Only Domestic Partners of active State employees are Eligible Dependents. State retirees and members of Special Groups may not enroll a Domestic Partner into the plan.);
- Effective January 1, 2011, Dependent Children are children to their 26th birthday who are not eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent. Effective January 1, 2014, unmarried dependent children under age 26 are eligible dependents regardless of whether or not they are eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent.
- Incapacitated Children; and/or
- newborn child for 60 days following birth.

Dependent Child(ren) includes:

- a son, daughter, foster child (if child has coverage through any other plan, to include a state of federal plan, due to their status as a foster child, this Plan will be secondary for benefits to the other plan), stepchild, and other children, the child of a Domestic Partner or partner through civil union;
- children for whom the Plan Participant, spouse, partner through civil union or Domestic Partner has been appointed legal guardian by a court; and
- legally adopted children. A child will be considered legally adopted from the time the child is placed in the home for the purpose of adoption if the Employee is legally obligated to provide full or partial support whether or not a final adoption order has been issued.

Note: A retiree may not add an Eligible Dependent during Open Enrollment.

Eligible Employee. An Employee, as described in Section II of this document, subject to the restrictions of Sections III through VI.

Eligible Expense. Expenses for services or supplies, but only to the extent that: (1) they are Medically Necessary, as defined in this Definitions section of the document; (2) the services or supplies are not excluded, as provided in the Exclusions section of this document; and (3) the Limited Lifetime, and/or Annual Maximum Benefits for those services or supplies has not been reached. Eligible Expenses are limited to Reasonable and Customary charges as defined in the Definitions section of this document.

Eligible Mental Health and Substance Abuse Expenses. Expenses for services payable under the mental health and substance abuse benefit of a plan option, but only to the extent that: (1) they are Medically Necessary, as defined in this Definitions section of the document; (2) the services are not excluded, as provided in the Exclusions section of this document; and (3) the Limited Lifetime, and/or Annual Maximum Benefits for those services has not been reached. Eligible Expenses are limited to Reasonable and Customary charges as defined in the Definitions section of this document.

Eligible Medical Expenses. Expenses for services or supplies payable under the medical benefit of a plan option, but only to the extent that: (1) they are Medically Necessary, as defined in this Definitions section of the document; (2) the services or supplies are not excluded, as provided in the Exclusions

section of this document; and (3) the Limited Lifetime, and/or Annual Maximum Benefits for those services or supplies has not been reached. Eligible Expenses are limited to Reasonable and Customary charges as defined in the Definitions section of this document.

Eligible Pharmacy Expenses. Expenses for prescription drugs payable under the pharmacy benefit of a plan option, but only to the extent that: (1) they are Medically Necessary, as defined in this Definitions section of the document; or (2) the drug is not excluded.

Emergency Medical Condition. Emergency medical condition means the sudden, and at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. placing the Member's physical or mental health in serious jeopardy, or
2. serious impairment to bodily functions or
3. serious dysfunction of any bodily organ or part

Emergency Services. Emergency Services means health care items and services furnished or required to evaluate and treat an Emergency Medical Condition.

Employee's Eligibility Date. The latter of the date of employment or the day after any applicable Waiting Period ends.

Enrollment/Change Application. A form, either paper or electronic, provided by the Department of Human Resources for the purpose of enrolling or changing the enrollment status of Employees, Eligible Dependents, or Covered Dependents. Proper completion of the form is required before any action regarding enrollment status can take place.

Exclusions. Specific conditions, circumstances, and limitations, as set forth in the Exclusions section of this document, for which the Plan does not provide Plan Benefits.

Hospital. An Acute Care facility as defined by the American Hospital Association. In no event, however, will the term "hospital" include any institution or part thereof which is used principally as a rest or nursing facility for the aged, chronically ill, convalescents, substance abusers, or a facility providing primarily custodial, educational or rehabilitation care.

Illness/Injury. Bodily or mental disorder of any kind. All such disorders due to injuries sustained by a person in one accident shall be considered one illness. Any such disorder that is the same as, or is related to, another existing or previously existing disorder shall be considered with that disorder as one illness.

Incapacitated Child. An Unmarried Dependent Child who is incapable of self-sustaining employment by reason of mental or physical disability that has been found to be a disability that qualifies or would qualify the child for benefits using the definitions, standards and methodology in 20 C.F.R Part 404, Subpart P and who became so incapable prior to attainment of the limiting age and who is chiefly dependent upon the Employee for support and maintenance. The Plan may require reasonable periodic proof of the continuing incapacitating condition no more frequently than once every year.

Initial Enrollment Period. The 60 day period commencing with the Date of Hire and ending on the 59th day following the Date of Hire.

In-Network Provider. A provider who has an agreement with the Plan Administrator and/or designee.

Inpatient. A patient at a facility who is admitted and incurs a room and board charge. The length of an Inpatient stay is computed by counting either the day of admission or the day of discharge, but not both.

Inpatient Substance Abuse Residential Treatment/Rehabilitation Facility. An institution (other than a Hospital) established to care for and treat those who need in-patient care due to alcoholism or narcotism. The institution must be licensed, registered or approved by the appropriate authority of the jurisdiction in which it is located. It must keep daily records on all patients.

Maximum Out-of-Pocket Expense. The sum of Deductibles and Coinsurance dollar limits. Maximum Out-of-Pocket Expense limits may be set for individuals and families for both in-network and out-of-network care. When the Maximum Out-of-Pocket Expense limit is reached, the Plan may pay 100% of any additional Eligible Medical Expense for the remainder of the Plan Year, subject to other Plan limitations. Any expenses for services and/or supplies not covered by the Plan (including care for which prior authorization was not obtained) and all charges in excess of Reasonable and Customary do not count toward the Maximum Out-of-Pocket Expense.

Maximum Plan Benefits. The maximum amount of Benefits payable by the Plan for Eligible Medical Expenses incurred by Member.

Annual Maximum Benefits. A maximum amount of Benefits or quantity of services or supplies a Member may receive each Plan Year for specified covered services and supplies. Once the Member has received the Annual Maximum Benefits for any specified covered services and supplies, the Plan will not pay any further Plan Benefits for the specified covered services and supplies for the balance of the Plan Year. Annual Maximum Plan Benefits are provided in the Schedule of Benefits. The Annual Maximum Benefits are not mutually exclusive of Limited Lifetime Maximum Benefits. Annual Maximum Benefits are applied to Lifetime Maximum Benefits.

The Plan has two types of Maximum Plan Benefits:

- **Limited Lifetime Maximum Benefit.** A maximum amount of Benefits payable or quantity of services or supplies a Member may receive for specified covered services and supplies during the entire time the Member is covered under this Plan. These Limited Lifetime Maximum Benefits pertain to “non-essential” benefits as defined by the Federal PPACA law. Limited Lifetime Maximum Benefits are provided in the Schedule of Benefits. If a Member terminates coverage and re-enrolls one or more times in the Plan, the Benefits paid or the quantity of services or supplies covered for the specified covered services and supplies for any period of enrollment are applied toward the Limited Lifetime Maximum Benefit. Once the Member has received a Limited Lifetime Maximum Benefit for a specified set of covered services and supplies during the lifetime, the Plan will not pay any further Plan Benefits for those services and supplies.
- **Annual Maximum Benefits.** A maximum quantity or number of days of services or supplies a Member may receive each Plan Year for specified covered services and supplies. Once the Member has received the Annual Maximum Benefits for any specified covered services and supplies, the Plan will not pay any further Plan Benefits for the specified covered services and supplies for the balance of the Plan Year. Annual Maximum Plan Benefits are provided in the Schedule of Benefits. The Annual Maximum Benefits are not mutually exclusive of Limited Lifetime Maximum Benefits. Annual Maximum Benefits are applied to Lifetime Maximum Benefits.

Medical or Scientific Evidence. Medical or scientific evidence means that which is found in:

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

Medically Necessary/Medical Necessity. Healthcare services and supplies, including diagnostic testing, preventive services and aftercare, appropriate in type, amount, frequency, level, setting and duration to the Member’s diagnosis or condition, and which are required for purposes other than the comfort and convenience of the Member or a Provider. Medically Necessary care is consistent with

generally accepted Medical or Scientific Evidence and guidelines or parameters resulting from such evidence, or, in the absence of such, care which is consistent with generally accepted practice parameters by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition; must be informed by the unique needs of each individual patient and each presenting situation and is clinically demonstrated to:

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

Medically Necessary care does not include services and supplies that are more than those required to meet the basic health need of the Member.

Even if a Provider prescribes, performs, orders, recommends or approves a service or supply, it might not be considered Medically Necessary. The final determination of Medical Necessity rests with the Plan Administrator or designee.

Member. An Employee or Eligible Dependent enrolled in the Plan.

Mental Health Residential Treatment Center. An institution which (a) specializes in the treatment of psychological and social functional disturbances that are the result of mental health conditions; (b) provides a sub-acute, structured, psychotherapeutic treatment program under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Residential Treatment Center when he is a registered bed patient in a Residential Treatment Center upon the recommendation of a Physician.

Mental Health Residential Treatment Services. Services provided by a Participating Provider for the evaluation and treatment of psychological and social functional disturbances that are a result of sub-acute mental health condition.

Network Provider. A Provider who has an agreement with the Plan Administrator or designee.

Nonparticipating Provider. A Provider who does not have an agreement with the Plan Administrator or designee.

Out-of-Network Provider. A Provider who does not have an agreement with the Plan Administrator or designee.

Outpatient. A patient who receives services from a Provider while not an Inpatient.

Participating Provider. A Provider who has an agreement with the Plan Administrator or designee.

Partner. Domestic Partner or Civil Union Partner.

Plan Administrator. The State of Vermont except to the extent the State has delegated such duty to a contractor or contractors. For healthcare services and supplies for which the State purchases insurance coverage, the insurer is the Plan Administrator.

Plan Year. The 12-month period from January 1 to December 31.

Premium. The amount payable in order to receive the coverage described in this document.

Prescription Drugs. Drugs that are:

- prescribed by a Provider who holds a license to prescribe from the Drug Enforcement Administration (DEA),
- FDA-approved, and
- approved by the Plan Administrator for reimbursement for the specific medical condition being treated or diagnosed.

Prior Approval/Prior Authorization/Pre-certification. An authorization that must be obtained from the Plan Administrator before receiving specified covered services. **Failure to obtain approval/authorization/certification before receipt of these specified services, may result in reduced or denied Benefits.**

Provider. A duly licensed and/or certified practitioner (means approved by the State in which they practice) only as listed below:

- Audiologist
- Chiropractors
- Christian Science Nurses and Practitioners (only as listed in the *Christian Science Journal*)
- Independent Clinical Laboratories
- Mental Health and Substance Abuse Professionals:
 - Clinical Mental Health Counselors
 - Clinical Psychologists
 - Clinical Social Workers
 - Psychiatric Nurse Midwives
 - Licensed Alcohol and Drug Abuse Counselors
- Nurses:
 - Certified Nurse Midwives

- Certified Registered Nurse Anesthetists
- Licensed Practical Nurses (LPN)
- Registered Nurses (RN)
- Naturopathic Physicians
- Nurse Practitioners
- Optometrists
- Physicians (Medical Doctors [MDs] and Doctors of Osteopathic Medicine [Dos])
- Physician's Assistants
- Dentists (Doctors of Medical Dentistry [DMDs] and Doctors of Dental Science [DDSs])
- Therapists (Occupational, Physical, and Speech)
- Podiatrists
- Facility, Durable Medical Equipment supplier, pharmacy

or other entity or professional that is"

- approved by the Plan Administrator,
- licensed and/or certified where required, and
- acting within the scope of that license and/or certification.

Reasonable and Customary (R&C) Charges. Reasonable charges are those that are customary and justifiable considering the resources consumed in the provision of the service or supply. Customary charges are those that fall within the range of charges for a similar service or supply billed by Providers in the same geographic area. Reasonable and Customary Charge determinations are made by the Plan Administrator or designee using published data provided by nationally recognized organizations such as the Health Insurance Association of America (HIAA). The term geographic area as used above means a county or larger area which provides a statistically valid base from which to ascertain an 80th percentile customary and reasonable charge. The maximum Eligible Expense for a Nonparticipating provider is set by the Plan at the 80th percentile of the R&C charges. If a Nonparticipating Provider bills less than the 80th percentile of the R&C Charges, the Eligible Expense is the billed charge. For Participating Providers, R&C is an agreed upon rate which might be established in a fee schedule or might be an agreed upon calculation. When a Benefit is specified in a Schedule of Benefits (e.g. 70%), it means the stated percentage of the agreed upon rate for Participating Providers; for Nonparticipating Providers it means the stated percentage of billed charges or the state percentage of the 80th percentile of R&C Charges, whichever is less.

Special Enrollment. Enrollment outside the Open Enrollment Period or the Initial Enrollment Period.

Special Groups. The Vermont State Employees' Association, Inc., the Vermont Historical Society, and the Vermont Council on the Arts.

Spouse. A person legally married to an Employee and not legally separated from the Employee.

State. State of Vermont.

Subrogation. The right of one party to be substituted in place of another party in a lawsuit. A health plan typically subrogates when third party liability is potentially associated with an injury or illness such that the Plan may recover medical benefits paid if a Member or former Member recovers any amount from a liable third party.

Thirty day waiting period. The 30-day period commencing on the Date of Hire and ending on the 29th day following the Date of Hire.

Totally Disabled. The inability of a Covered Employee or an adult Member who is/was employed to engage in any employment or occupation for which he is or becomes qualified by reason of education, training or experience and is not, in fact, engaged in any employment or occupation for wage or profit.

Non-working Members shall be deemed Totally Disabled if they cannot perform the normal activities or duties of a person of the same age and gender.

The Totally Disabled Member must be under the regular care of a Physician.

Urgent Care/Urgently Needed Care. Health services that are necessary to treat a condition or illness of a Member that if not provided promptly (within 24 hours or a time frame consistent with the exigencies of the case) presents a serious risk of harm.

Waiting Period. A time during which an Employee is employed by the State or a Special Group but is not eligible to be covered by the Plan.