

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.