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State of Vermont

Essential Health Benefits Benchmark Plan

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I. Summary and Scope of Coverage

The following Essential Health Benefits (EHB) benchmark plan is provided as a summary of covered services and supplies in major medical health insurance coverage in Vermont starting in Plan Year 2024. This EHB Benchmark plan is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not. Additionally, this EHB Benchmark plan is not effective until approved by the Centers for Medicare and Medicare Services (CMS) under the process outlined in 45 CFR § 156.111.

On March 2, 2022, the Green Mountain Care Board voted unanimously to adopt the recommendation of the Commissioner of Vermont Health Access to exercise the flexibility available under 45 C.F.R. § 156.111 to create a new EHB-benchmark plan for Plan Year 2024 that includes all the existing benefits within the current benchmark plan and coverage for hearing aids – up to one hearing aid per ear every three years and an annual exam.

Nothing in this EHB Benchmark plan is intended or should be construed to mandate additional Essential Health Benefits under federal law. At no time shall the set of benefits listed below be construed to allow an issuer to deny coverage for any and all federal and state required benefits.

II. Detail of Benefits

A. Disclaimer

To the extent that the Essential Health Benefits (EHB) benchmark plan does not comply with current federal requirements, including the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), individual and small group market issuers must conform plan benefits to meet federal requirements. This includes ensuring that the availability of benefits is not discriminatory under federal law.

There may be United States Pharmacopeia (USP) Classes that do not have any drugs covered under the benchmark plan. Under 45 C.F.R. § 156.122, health plans are required to cover at least the greater of: one drug in every USP Category and Class or the same number of prescription drugs in each category and class as the EHB Benchmark. Consequently, regardless of the benchmark, issuers must cover at least one drug in every USP Category and class.

Except where expressly noted, covered services may be subject to deductibles, co-payment and coinsurance amounts, fee or benefit limits, practice parameters, and utilization review consistent with applicable state and federal law.

B. Covered Services

1. Preventive Services

Preventative Services are covered with no cost-sharing for Covered Persons to the extent required by 42 U.S.C. § 300gg–13.

Coverage for other preventive, diagnostic, and treatment services may be subject to cost-sharing. Cost-sharing may also apply if a Provider finds or treats a condition while performing Preventive Services.

2. Office Visits

Professional services, including but not limited to the following, are covered when delivered in an office setting:

- examination, diagnosis, and treatment of an injury or illness;
- injections;
- diagnostic services, such as X-rays;
- nutritional counseling;
- surgery; and
- therapy services.

Some office visits may fall under the Preventive Services benefit, described above. Some office visit benefits have special requirements or limits and may have additional cost-sharing.

In addition to any General Exclusions that may apply, health plans may exclude immunizations that the law mandates an employer to provide.

Office visits for mental health services, substance use disorder treatment services, and chiropractic services are further described below. Please refer to those sections for benefits.

3. Abortion

Abortion and any related services, drugs, or supplies are covered.

4. Ambulance

Ambulance services are covered for Emergency Medical Conditions. Coverage for Emergency Medical Services outside of the service area is the same as coverage within the service area.

For purposes of this EHB Benchmark, "Emergency Medical Condition" shall have the same meaning as in 42 U.S.C. § 300gg–111(a)(3)(B).

Transportation of the sick and injured is covered:

- to the nearest Facility from the scene of an accident or medical emergency; or
- between Facilities or between a Facility and home (but not solely according to the patient's or the Provider's preference).

Health plans may place the following limitations on coverage:

- requiring Prior Approval for non-emergency transport including air or water transport;
- limiting coverage to transportation to the closest Facility that can provide services appropriate for the treatment of a Covered Person's condition.
- excluding coverage when a Covered Person can be safely transported by any other means; and
- excluding coverage when transportation is solely for the convenience of the Provider, family, or Covered Person.

5. Autism Spectrum Disorder

Medically Necessary services related to Autism Spectrum Disorder (ASD), which includes Asperger's Syndrome, moderate or severe Intellectual Disorder, Rett Syndrome, Childhood Disintegrative Disorder (CDD), and Pervasive Developmental Disorder—Not Otherwise Specified (PDD-NOS), are covered.

6. Bariatric Surgery

Bariatric Surgery is covered.

In addition to any General Exclusions that may apply, health plans may limit coverage to specific Health Care Facilities for clinical quality purposes.

7. Clinical Trials & Studies

Medically Necessary, routine patient care services for Covered Persons enrolled in Approved Clinical Trials are covered to the extent required by 8 V.S.A. § 4088b.

For purposes of this EHB Benchmark, "Approved Clinical Trial" means an organized, systematic, scientific study of therapies, tests, or other clinical interventions for purposes of treatment, palliation, or prevention of cancer in human beings.

General Exclusions may apply.

8. Chiropractic Care

Acute and supportive chiropractic care (only for services that require constant attendance of a Chiropractor) is covered to the extent required by 8 V.S.A. § 4088a, including:

- office visits, spinal and extraspinal manipulations and associated modalities;
- home, hospital, or nursing home visits; or
- diagnostic services (e.g., labs and X-rays).

Services provided by Chiropractors are covered when the services are provided within the scope of the Chiropractor's license to treat a Covered Person's neuromusculoskeletal condition.

Requirements and conditions that apply to coverage for services by Providers other than Chiropractors also apply to this coverage.

If Covered Persons use more than twelve chiropractic visits in one Plan Year, health plans may require Prior Approval for any visits after the twelfth.

In addition to any General Exclusions that may apply, health plans may exclude the following chiropractic benefits:

- services, including modalities, that do not require the constant attendance of a Chiropractor;
- treatment of any "visceral condition," that is a dysfunction of the abdominal or thoracic organs, or other condition that is not neuromusculoskeletal in nature;
- acupuncture;
- hot and cold packs;
- massage therapy;
- care provided but not documented with clear, legible notes indicating the patient's symptoms, physical findings, the Chiropractor's assessment, and treatment modalities used (billed);
- low-level laser therapy;
- vertebral axial decompression;
- supplies or Durable Medical Equipment;
- treatment of a mental health condition;

- prescription or administration of drugs;
- obstetrical procedures including prenatal and post-natal care;
- Custodial Care, as noted in General Exclusions;
- supervised services or modalities that do not require the skill and expertise of a licensed Provider;
- Surgery;
- unattended services or modalities (application of a service or modality) that do not require one-on-one patient contact by the Provider; or
- any other procedure not listed as a Covered chiropractic service.

9. Contraceptive Care and Sterilization

Outpatient contraceptive services, including sterilizations, are covered to the extent required by 8 V.S.A. § 4099c and the Affordable Care Act.

All prescription contraceptives and prescription contraceptive devices approved by the Food and Drug Administration (FDA) are covered to the extent required by 8 V.S.A. § 4099c, including:

- a supply of prescribed contraceptives intended to last over a 12-month duration, which may be furnished or dispensed all at once or over the course of the 12 months at the discretion of the health care provider.
- self-administered hormonal contraceptives prescribed for a Covered Person by a pharmacist in accordance with 26 V.S.A. § 2023.

Under 8 V.S.A. § 4099c, health plans may not establish any rate, term, or condition that places a greater financial burden on an insured or beneficiary for access to contraceptive services, prescription contraceptives, or prescription contraceptive devices than for access to services, treatment, prescriptions, or devices for any other health condition.

Under 8 V.S.A. § 4099c, health plans must cover the following contraception and sterilization services with no cost-sharing for Covered Persons:

- at least one drug, device, or other product within each method of contraception for women identified by the FDA and prescribed by a Covered Person's Provider;
    - If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, health plans may provide coverage for more than one drug, device, or other product and may impose cost-sharing requirements as long as at least one drug, device, or other product for that method is available without cost-sharing;

    - If a Covered Person's Provider recommends a particular service or FDA-approved drug, device, or other product for the Covered Person based on a determination of medical necessity, health plans shall defer to the Provider's determination and judgment and shall provide coverage without cost-sharing for the drug, device, or product prescribed by the Provider for the Covered Person.
- patient education and counseling by the Covered Person's Provider regarding the appropriate use of the contraceptive method prescribed;
- voluntary sterilization procedures for men and women, regardless of Medical Necessity, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223;
- clinical services associated with providing the drugs, devices, products, and procedures covered under 8 V.S.A. § 4099c and related follow-up services, including management of side effects, counseling for continued adherence, and device insertion and removal.

10. Cosmetic and Reconstructive Procedures

Cosmetic Procedures are excluded. Please refer to General Exclusions for details.

Reconstructive Procedures are covered when Medically Necessary unless expressly excluded in this EHB Benchmark.

For purposes of this EHB Benchmark, "Reconstructive Procedures" are Medically Necessary procedures to correct gross deformities with physiological and functional impairments attributable to congenital defects, injury (including injuries occurring at birth), disease, or other health conditions (including gender dysphoria).

"Reconstructive Procedures" include reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas, following Medically Necessary removal of all or part of a breast or breasts.

Under the Women's Health and Cancer Rights Act of 1998 (WHCRA), the following services are covered after a mastectomy:

- reconstruction of the breast or breasts on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance;
- prostheses (artificial replacements); and/or

- services for physical complications resulting from the mastectomy.

11. Craniofacial Disorders

Diagnosis and Medically Necessary treatment of musculoskeletal disorders that affect any bone or joint in the face, neck, or head and are the result of accident, trauma, congenital defect, developmental defect, or pathology is covered to the extent required by 8 V.S.A. § 4089g.

Health plans may require a referral from an in-network Provider as a condition of coverage.

12. Dental Services

Certain dental services for adults and pediatrics are covered, as listed below.

a. Adult Services

The following services are covered for Covered Persons over age 21:

- treatment for, or in connection with, an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment begins within six months of the accident;
- Surgery to correct gross deformity resulting from major disease or Surgery (Surgery must take place within six months of the onset of disease or within six months after Surgery, except as otherwise required by law);
- Surgery related to head or neck cancer where sound natural teeth may be affected primarily or as a result of the chemotherapy or radiation treatment of that cancer;
- Treatment for a congenital or genetic disorder, such as but not limited to the absence of one or more teeth, up to the first molar, or abnormal enamel; and
- Facility and anesthesia charges for Covered Persons with severe disabilities that preclude office-based dental care due to safety considerations.

Health plans may not cover the professional charges for dental services.

b. Pediatric Services

In addition to the above dental services for Covered Persons over age 21, the following services are covered for Covered Persons under age 21:

- Class I services including examinations and cleanings every 180 days, X-rays and diagnosis;

- Class II (basic) services including simple restoration (fillings), crowns and jackets, repair of crowns, wisdom tooth removal, extractions, and endodontics (root canal);
- Class III (major) services including dentures, bridges, replacement of bridges and dentures, and Medically Necessary orthodontia; and/or

c. Anesthesia

Facility and anesthesia charges are covered to the extent required by 8 V.S.A. § 4100i for all Covered Persons.

d. Exclusions

Unless expressly required by law, health plans may exclude the following dental services in addition to any General Exclusions that may apply:

- Surgical removal of teeth, including removal of wisdom teeth;
- gingivectomy;
- tooth implants, including those for the purpose of anchoring oral appliances, unless for the treatment of an accidental injury, trauma, or cancer-related treatment;
- care for periodontitis;
- injury to teeth or gums as a result of chewing or biting;
- pre- and post-operative dental care;
- orthodontics (including orthodontics performed as an adjunct to orthognathic Surgery or in connection with an accidental injury);
- procedures designed primarily to prepare the mouth for dentures; or
- charges related to non-Covered dental procedures or anesthesia.

13. Diabetes Services

Treatment of diabetes is covered, subject to the same terms and conditions used for other medical treatments.

As required by 8 V.S.A. § 4089c, coverage includes equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes, and noninsulin using diabetes.

In addition to any General Exclusions that may apply, health plans may require nutritional counseling from one of the following providers:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- registered dietitian (R.D.);
- certified dietitian (C.D.);
- naturopathic doctor (N.D.);
- advanced practice registered nurse (A.P.R.N.); or
- certified diabetic educator (C.D.E.).

14. Diagnostic Tests

Diagnostic Tests to help find or treat a condition are covered, including:

- imaging (radiology, X-rays, ultrasound, and nuclear imaging);
- studies of the nature and cause of disease (laboratory and pathology tests);
- medical procedures (ECG and EEG);
- allergy testing (percutaneous, intracutaneous, patch, and RAST testing);
- mammograms; and/or
- hearing tests by an audiologist for the purpose of diagnosing a disease condition.

Health plans may require Prior Approval for special radiology procedures (including CT, MRI, MRA, MRS, PET scans, and echocardiograms), polysomnography (sleep studies), and laboratory services as determined by the plan.

Health plans may limit coverage of laboratory and pathology tests, including genetic testing and molecular pathology procedures, to in-network laboratories.

Health plans may require that a Provider refer Covered Persons to an audiologist as a condition of coverage for an audiologist's laboratory hearing test when they find or reasonably suspect a disease condition or injury of the ear.

15. Emergency Services

Emergency Services are covered to the extent required by Regulation H-2009-03 and the No Surprises Act.

Health plans may not require Prior Approval for Emergency Services.

For purposes of this EHB Benchmark, "Emergency Services" shall have the same meaning as in 42 U.S.C. § 300gg–111(a)(3)(C).

16. Gender Dysphoria

Medically Necessary treatment for gender dysphoria and related health conditions is covered to the extent required by 8 V.S.A. § 4724 and Insurance Bulletin 174.

17. Hearing Aids

The following hearing aid services are covered when Medically Necessary:

- analog or digital hearing aids, plus their repair, replacement, or modification,
- prescriptions for hearing aid batteries,
- fitting, orientation, and/or checking of hearing aids, and
- ear molds specific to hearing aids.

Health plans may limit coverage to one of the following conditions:

- hearing loss in the better ear is greater than 30dB, based on an average taken at 500, 1000, and 2000Hz;
- unilateral hearing loss is greater than 30dB, based on an average taken at 500, 1000, and 2000Hz; and/or
- hearing loss in the better ear is greater than 40dB, based on an average taken at 2000, 3000, and 4000Hz, or word recognition is poorer than 72%.

Health plans may limit coverage of hearing aids to one hearing aid per ear every three years for specified degree of hearing loss. Health plans may also limit coverage of hearing aid repairs to 50% of the replacement cost.

In addition to any General Exclusions that may apply, health plans may exclude coverage for non-medical items and fees associated with selection trial periods or loaners.

18. Home Care

The following Acute services of a Home Health Agency or Visiting Nurse Association are covered:

- Medically Necessary skilled nursing procedures in the home;
- Training for family or other caregivers to perform necessary procedures in the home; or
- Physical, Occupational, or Speech Therapy.

The below services are also covered when provided in the home to the extent required by 8 V.S.A. § 4096:

- a Provider's visit for Palliative care, excluding non-medical charges;
- services of a home health aide for personal care when receiving skilled nursing or therapy services;
- other necessary services furnished and billed by a Home Health Agency or Visiting Nurse Association; and
- home infusion therapy.

Skilled nursing services by a private duty nurse outside of a hospital are covered, subject to the below limitations:

- health plans may limit benefits for private duty nursing; and/or
- health plans may limit benefits to services from a registered or licensed practical nurse.

Health plans may limit coverage of home infusion therapy to:

- a prescribed home infusion therapy regimen; or
- services from an in-network home infusion therapy Provider.

Health plans may exclude coverage for a Provider to administer home infusion therapy when the patient or an alternate caregiver can be trained to do so.

In addition to any General Exclusions that may apply, health plans may exclude coverage for the following home care benefits:

- homemaker services;
- drugs or medications except as otherwise noted;
- Custodial Care, as noted in General Exclusions;
- food or home-delivered meals;
- non-medical charges; and
- private duty nursing services provided at the same time as home health care nursing services.

19. Hospice Care

The following services are covered when provided by a Hospice Provider:

- skilled nursing visits;
- home health aide services for personal care services;

- homemaker services for house cleaning, cooking, etc.;
- continuous care in the home;
- Respite Care services;
- Hospice services in a Health Care Facility;
- social worker visits before the Covered Person's death and bereavement visits and counseling for family members up to one year following the Covered Person's death; and
- other Medically Necessary services.

Health plans may require the following as a condition of coverage:
- that the Covered Person and the Provider consent to the Hospice care plan; and
- that a primary caregiver will be in the home.

20. Infertility Services

Evaluations to determine if and why a covered member is infertile are covered.

In addition to any General Exclusions that may apply, health plans may exclude the following infertility services and medications:

- medications for treatment of infertility when used for treatment of infertility; and
- surgical, radiological, pathological or laboratory procedures leading to or in connection with:
  - artificial insemination;
  - in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT);
  - zygote intrafallopian transfer (ZIFT); and
  - any variations of the above procedures, including costs associated with collection, washing, preparation or storage of sperm for artificial insemination including donor fees, cryopreservation of donor sperm and eggs.

21. Inpatient Care and Services

Inpatient care in a Health Care Facility is covered, including:

- room and board;
- otherwise covered "ancillary" services; and
- supplies, including drugs.

Services performed on an inpatient basis by a Physician or Professional Provider in a Health Care Facility are covered, including:

- Surgery;
- services of an assistant surgeon when necessary;
- anesthesia services;
- intensive care; or
- Medically Necessary specialty care.

22. Maternity and Newborn Services

Maternity care is covered to the extent required by Insurance Regulation I-1989-01 and the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA). Inpatient maternity stays are covered under the Inpatient Care and Services benefit, described above.

The following care by a Provider or other Professional during a Covered Person's pregnancy is also covered:

- prenatal visits and other care;
- delivery of a baby, whether at home or in a Health Care Facility;
- post-natal visits; and
- well-baby care and an initial hospital visit for the baby while an Inpatient.

Health plans may limit coverage for care performed by certified nurse midwives and licensed midwives to in-network Providers.

Non-hospital grade breast pumps are covered with no cost-sharing.

Newborns are covered for up to 60 days after birth as required by 8 V.S.A. § 4092. The newborn may be subject to their own cost-sharing for covered services beginning on their date of birth, whether or not the newborn is added to coverage permanently.

23. Medical Equipment and Supplies

a. Durable Medical Equipment (DME)

The rental or purchase of Durable Medical Equipment (DME) is covered.

Health plans may reserve the right to determine whether rental or purchase of the equipment is more appropriate.

Health plans may limit coverage to DME purchased or rented from in-network Providers, including DME suppliers.

b. Replacement of Lost, Stolen or Destroyed Equipment

Replacement of one lost, stolen, or destroyed DME, prosthetic, or orthotic per Plan Year is covered if:

- it is still under warranty (including but not limited to homeowners' insurance and automobile insurance); and/or
- the equipment's absence would put the Covered Person at risk of death, disability, or significant negative health consequences such as a hospital admission.

Health plans may require Covered Persons to submit documentation, such as a police report, in order to replace a stolen item.

c. Supplies

Medical supplies such as needles and syringes and other supplies for treatment of diabetes, dressings for cancer or burns, catheters, colostomy bags and related supplies, and oxygen, including equipment Medically Necessary for its use, are covered.

d. Orthotics

Molded, rigid, or semi-rigid support devices that restrict or eliminate motion of a weak or diseased body part are covered.

Health plans pay require Prior Approval for orthotics with a purchase price of $500 or more.

e. Prosthetics

The purchase, fitting, necessary adjustments, repairs, and replacements of prosthetics is covered, including prosthetic devices that are attached to (or inserted into) prosthetic shoes, and prosthetics which otherwise replace a missing body part.

Health plans may limit coverage to devices surgically implanted or worn as an anatomic supplement to replace:

- all or part of an absent body organ (including contiguous tissue and hair);
- hair lost due to chemotherapy and/or radiation therapy, third-degree burns, traumatic scalp injury, congenital baldness present since birth, and medical conditions resulting in alopecia areata or alopecia totalis (with exclusions as noted below in section III);
- the lens of an eye; or

- all or part of the function of a permanently inoperative, absent or malfunctioning body part.

f. Limitations

Health plans may limit replacement of wigs (cranial/scalp prosthesis) to one wig every three years.

Health plans may limit coverage of eyeglasses or contact lenses to:

- treatment of aphakia or keratoconus;
- one set of accompanying eyeglasses or contact lenses for the original prescription; and
- one set for each new prescription.

Health plans may limit coverage of dental prostheses to those required:

- to treat an accidental injury (except injury as a result of chewing or biting);
- to correct gross deformity resulting from major disease, congenital anomalies that result in impaired physical function or Surgery;
- to treat obstructive sleep apnea; or
- to treat craniofacial disorders, including temporomandibular joint syndrome.

g. Exclusions

In addition to any General Exclusions that may apply, health plans may exclude the following services:

- treatment for hair loss;
- dental appliances or dental prosthetics, except as listed above;
- shoe insert orthotics, lifts, arch supports, or special shoes not attached to a brace (except with a diagnosis of diabetes);
- custom-fabricated or custom-molded knee braces for which Covered Persons have not received Prior Approval;
- duplicate medical equipment and supplies, orthotics, and prosthetics;
- dynamic splinting, patient-actuated end-range motion stretching devices and programmable or variable motion resistance devices;
- items or equipment that are not DME, as defined in 42 C.F.R. § 414.202;
- any treatment, DME, supplies, or accessories intended principally for participation in sports or recreational activities or for personal comfort or convenience; and

- repair or replacement of dental appliances or dental prosthetics except as listed above.

24. Mental Health Care

Inpatient and Outpatient mental health services are covered, including:

- individual and Group Outpatient psychotherapy;
- hospitalization;
- family and couples therapy;
- Intensive Outpatient Programs (IOP);
- partial hospital day treatment;
- psychological testing when integral to treatment;
- psychotherapeutic programs directed toward improving compliance with prescribed medical treatment regimens for such chronic conditions as diabetes, hypertension, ischemic heart disease, and emphysema; and
- Residential Treatment Programs.

Health plans may require Prior Approval for mental health services as determined by the plan.

Under 8 V.S.A. § 4089b, health plans may not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental condition than for access to treatment for other health conditions.

Health plans may limit coverage of mental health services to care provided in the least restrictive setting Medically Necessary.

In addition to any General Exclusions that may apply, health plans may exclude the following services:

- services ordered by a court of law (unless Medically Necessary);
- treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required;
- non-traditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs that focus on education, socialization or delinquency, as noted in General Exclusions;
- Custodial Care, as noted in General Exclusions;
- psychoanalysis;

- hypnotherapy; and
- biofeedback, pain management, stress reduction classes and pastoral counseling.

25. Naturopathic Services

Naturopathic services are covered to the extent required by 8 V.S.A. § 4088d.

26. Nutritional Counseling

Nutritional counseling is covered.

Health plans may limit coverage of nutritional counseling to the following Provider types:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- registered dietician (R.D.);
- certified dietician (C.D.);
- naturopathic doctor (N.D.);
- advanced practice registered nurse (A.P.R.N.); or
- certified diabetic educator (C.D.E.).

27. Outpatient Care and Services

Outpatient care, such as chemotherapy (including growth cell stimulating factor injections), Outpatient Surgery, and diagnostic testing (like X-rays), is covered. Coverage may include:

- Facility services;
- Professional services; and
- Related supplies.

Services performed on an Outpatient basis by a Physician or Professional Provider are covered, including:

- Surgery;
- Abortion and any related services, drugs or supplies;
- Services of an assistant surgeon when necessary; and
- Anesthesia services.

28. Prescription Drugs and Biologics

The following services are covered for Medically Necessary Outpatient use:

- Prescription Drugs and Biologics (including contraceptive drugs and devices that require a prescription) if the Food and Drug Administration (FDA) approves them for the treatment, prevention or diagnosis of a Covered Person's condition; and/or
- Insulin and other supplies for people with diabetes (glucose testing materials including home glucose testing machines, needles, and syringes).

Under 8 V.S.A. § 4089i(c), a Covered Person's total out-of-pocket responsibility for Prescription Drugs and Biologics is limited to no more for self-only and family coverage per year than the minimum dollar amounts in effect under 26 U.S.C. § 223(c)(2)(A)(i) for self-only and family coverage, respectively.

Under 8 V.S.A. § 4089i and Insurance Bulletin 220, a Covered Person's total out-of-pocket responsibility for prescription insulin medications (including any drug containing insulin) may not be more than $100 per 30-day supply, regardless of the amount, type, or number of medications prescribed. However, a policyholder who receives more than thirty days' supply of insulin in a given month, for use over a longer period, may be billed more than $100 in that month. This out-of-pocket maximum shall apply even if the policyholder has not met his or her annual deductible, and in no instance may a policyholder's total out-of-pocket responsibility for prescription medication exceed the maximum established under 8 V.S.A. § 4089i(c).

Health plans may not require, as a condition of coverage, use of Prescription Drugs and Biologics not indicated by the FDA for the condition diagnosed and being treated under supervision of a health care professional to the extent required by 8 V.S.A. § 4089i(f)(1).

Health plans must apply the same cost-sharing requirements to interchangeable biological products as apply to generic drug to the extent required by 8 V.S.A. § 4089i(g).

Prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells are covered on the same basis as intravenously administered or injected anticancer medications to the extent required by 8 V.S.A. § 4100h. Off-label Prescription Drugs and Biologics used to treat cancer are also covered if their use is Medically Necessary.

At least two attempts of tobacco-cessation medication of 90 days each per year, including over-the-counter medication, is covered to the extent required by 8 V.S.A. § 4100j, Insurance Bulletin 193, and the Affordable Care Act.

Health plans may require different amounts of cost-sharing when Covered Persons purchase generic, preferred brand, or non-preferred brand drugs. For purposes of this EHB Benchmark, the term "preferred" means drugs that are included in the health plan's drug formulary. The term "non-preferred" means drugs that are not included in the health plan's drug formulary.

Health plans may limit coverage for controlled substances, antibiotics, Specialty Medications, and compound drugs to a 30-day supply for each refill; for other medications, a 90-day supply for each refill; contraceptives up to a 12-month supply; and prescribed tobacco cessation drugs to a six-month supply per plan year.

Health plans may require Prior Approval or Step Therapy for Prescription Drugs or Biologics. For purposes of this EHB Benchmark, the term "Step Therapy" shall have the same meaning as in 8 V.S.A. § 4089i(h)(5).

Health plans may review Prescription Drugs or Biologics for Medical Necessity if the amount of a drug prescribed exceeds quantity limits as determined by the plan.

Health plans may require that Covered Persons receive specialty drugs and supplies from a specialty medication network as determined by the plan and to the extent permitted by law.

Replacement of one lost, stolen, or destroyed Prescription Drug or Biologic per Plan Year for Prescriptions Drugs or Biologics filled through a pharmacy is covered if:

- it is still under warranty (including but not limited to homeowners' insurance and automobile insurance); and/or
- the Prescription Drug or Biologic's absence would put the Covered Person at risk of death, disability, or significant negative health consequences such as a hospital admission.

Health plans may require Covered Persons to submit documentation, such as a police report, in order to replace a stolen item. Health plans may decline to cover replacement of a lost, stolen or destroyed Prescription Drug or Biologic:

- for more than one lost, stolen, or destroyed Prescription Drug or Biologic per Plan Year filled through a pharmacy; or
- for lost, stolen, or destroyed Prescription Drugs and Biologics received through the Inpatient Care and Services benefit.

In addition to any General Exclusions that may apply, health plans may exclude the following under the Prescription Drugs and Biologics benefit:

- all medications for treatment of infertility;
- refills beyond one year from the original prescription date;
- devices of any type other than prescription contraceptives and insulin pumps, even though such devices may require a prescription including, but not limited to:

Durable Medical Equipment, prosthetic devices, appliances, and supports (although benefits may be provided under other sections of this EHB Benchmark);

- any drug considered to be Experimental or Investigational, except for certain Off-label cancer drugs and drugs administered as part of certain clinical cancer trials;
- Viagra, Cialis, Levitra, Addyi, and other drugs to treat sexual dysfunction;
- vitamins, except those which, by law, require a prescription;
- drugs that do not require a prescription, even if prescribed or recommended by a Provider;
- any drugs excluded under the health plan's formulary drug list. Covered Persons may request benefit exceptions;
- the replacement of lost, stolen, or destroyed Prescription Drugs or Biologics received through the Inpatient Care and Services benefit;
- Unless approved by the health plan, drugs:
  - Not approved by the FDA; and
  - Not in general use as of March 1 of the prior Plan Year.
- Drugs newly approved by the FDA until they have been reviewed and approved by the health plan.

29. Rehabilitation and Habilitation

Rehabilitation and Habilitation services are covered, including:

- Inpatient treatment in a Network Physical Rehabilitation Facility for a medical condition requiring Acute Care;
- Outpatient cardiac or pulmonary Rehabilitation for a condition requiring Acute Care; and/or
- Rehabilitative or Habilitative services and devices Covered elsewhere in this EHB Benchmark, for instance, under Therapy Services.

Health plans may require as a condition of coverage that the attending Provider:

- certify that services of a Physical Rehabilitation Facility are required and are the most appropriate level of care for the condition being treated; and
- re-certify on a schedule based upon the Covered Person's clinical condition, but no less frequently than every 30 days, that the services are Medically Necessary, and that the Covered Person is making significant progress.

Health plans may require prior approval for more than 30 combined Rehabilitation and Habilitation services in one Plan Year.

In addition to any General Exclusions that may apply, health plans may exclude the following services:

- Custodial Care, as noted in General Exclusions; and/or
- cognitive re-training or educational programs.

30. Skilled Nursing Facility

Inpatient Skilled Nursing Facility services are covered, including:

- room, board (including special diets), and general nursing care;
- medication and drugs given by the Skilled Nursing Facility during a Covered stay; and
- medical services included in the rates of a Skilled Nursing Facility.

Health plans may require as a condition of coverage that the Covered Person:

- request Prior Approval for Inpatient services;
- receive Acute Care in the Skilled Nursing Facility; and
- receive services from an in-network Skilled Nursing Facility.

In addition to any General Exclusions that may apply, health plans may exclude the following services:

- Custodial Care, as noted in General Exclusions;
- cognitive re-training or educational programs.

31. Substance Use Disorder Treatment Services

The following Acute substance use disorder treatment services are covered:

- detoxification;
- Intensive Outpatient Programs (IOP);
- short-term Residential Treatment Programs;
- Outpatient Rehabilitation (including services for the Covered Person's family when necessary); and/or
- Inpatient Rehabilitation.

Health plans may limit coverage of substance use disorder treatment services to Medically Necessary Care in the least restrictive setting.

In addition to any General Exclusions that may apply, health plans may exclude substance use disorder treatment benefits for:

- services ordered by a court of law (unless deemed Medically Necessary);
- non-traditional, alternative therapies such as Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required;
- services, including long-term residential programs, adventure-based activities, wilderness programs, and residential programs that focus on education, socialization, or delinquency;
- Custodial Care, as noted in General Exclusions;
- biofeedback, pain management, stress reduction classes, and pastoral counseling;
- psychoanalysis; and
- hypnotherapy.

32. Surgery

Surgery is covered in both Inpatient and Outpatient settings.

Voluntary sterilization procedures for men and women are covered without cost-sharing, regardless of Medical Necessity, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.

Health plans may place the following limitations on Surgery services:

- If a Covered Person has several Surgeries at the same time, health plans may not pay a full allowance for each one; and
- Covered Persons must get Prior Approval for Cosmetic and Reconstructive procedures.

General Exclusions may apply.

33. Telemedicine and Audio-Only Telephone Services

Telemedicine and Audio-Only Telephone Services are covered to the extent required by 8 V.S.A. §§ 4100k & 4100l.

For purposes of this EHB Benchmark, the term "Telemedicine" shall have the same meaning as in 8 V.S.A. § 4100k(i)(7).

34. Therapy Services

Therapy or Physical Medicine Services from the following Providers are covered:

- an in-network Health Care Facility, Skilled Nursing Facility, or Home Health Agency/Visiting Nurse Association;
- a licensed therapist (Occupational, Physical, and Speech);
- a medical doctor (M.D.), doctor of osteopathy (D.O.), or Chiropractor (D.C.) in an office or home setting; or
- an athletic trainer (A.T.) in a clinical setting (an Outpatient orthopedic or sports medicine clinic that employs an M.D., D.O., D.C., or licensed physical therapist).

Therapy or Physical Medicine Services could include the following:

- chemotherapy or radiation treatment (including growth cell stimulating factor injections);
- dialysis treatment;
- Physical Therapy/physical medicine;
- Occupational Therapy;
- Speech Therapy; and
- infusion therapy.

Health plans may limit coverage of Therapy or Physical Medicine Services:

- for services that require the constant attendance of a licensed:
  - therapist (Occupational, Physical and Speech),
  - medical doctor (M.D.),
  - Chiropractor (D.C.),
  - athletic trainer (A.T.),
  - podiatrist (D.P.M.),
  - nurse practitioner (N.P.),
  - advanced practice registered nurse (A.P.R.N.),
  - doctor of naturopathy (N.D.); or
  - doctor of osteopathy (D.O.).
- Up to a specific benefit limit determined by the plan.

Health plans may require Prior Approval for Therapy or Physical Medicine Services, provided that availability of benefits is not discriminatory under federal law.

Health plans may require prior approval for more than 30 combined Occupational, Speech and Physical Therapy/medicine services in one Plan Year.

Evidence-based diagnosis and treatment of early childhood developmental disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst is covered to the extent required by 8 V.S.A. § 4088i.

In addition to any General Exclusions that may apply, health plans may exclude the following Therapy or Physical Medicine Services:

- care for which there is no therapeutic benefit or likelihood of improvement;
- care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the result of treatment or the individual's medical progress;
- care provided, but not documented with clear, legible notes indicating the Covered Person's symptoms, physical findings, the Provider's assessment, and treatment modalities used (billed);
- group physical medicine services, group exercise, or Physical, Occupational, or Speech Therapy performed in a group setting;
- therapy services provided as part of Custodial Care;
- services, including modalities, that do not require the constant attendance of a Provider;
- hot and cold packs;
- supervised services or modalities that do not require the skill and expertise of a licensed Provider; or
- unattended services or modalities (application of a service or modality) that do not require one-on-one patient contact by the Provider.

35. Transplant Services

Transplant services are covered, including the following services:

- search for a donor;
- surgical removal of an organ;
- storage and transportation costs for the organ, partial organ, or bone marrow; and
- costs directly related to the solid organ or bone marrow donation, including costs resulting from complications of the donor's Surgery.

Health plans may require Prior Approval for Transplant services, and may review all requests based on:

- the patient's medical condition;

- the qualifications of the Providers performing the transplant procedure; and
- the qualifications of the Facility hosting the transplant procedure.

Health plans that cover both the recipient and the donor may apply benefits to each under their own respective contract.

Health plans that cover the recipient, but not the donor, may apply benefits to both under the recipient's contract, and may limit benefits paid to the donor to services that occur within 120 days from the date of the donor's Surgery.

If an otherwise covered transplant procedure is not completed, health plans may provide benefits only if the procedure was scheduled to occur within 24 hours of the donor's Surgery.

In addition to any General Exclusions that may apply, health plans may exclude:

- Transplant Services if the donor is covered, but not the recipient;
- the purchase price of any organ or bone marrow that is sold rather than donated.

36. Vision

Vision care benefits are covered for Covered Persons up to 21 years of age.

One routine vision examination each Plan Year for a Covered Person under 21 years of age (and to the end of the Plan Year in which the Member turns 21) is covered. This exam assesses the Covered Person's visual function to:

- determine if there are any visual problems and/or abnormalities; and
- prescribe any necessary corrective eyewear.

a. Vision Materials

The following supplies and services are covered for covered up to 21 years of age (and to the end of the Plan Year in which the Member turns 21):

- one pair of frames and/or lenses for prescription glasses and related Professional services each Plan Year; or
- one pair of contact lenses and related Professional services each Plan Year.

b. Lenses for Prescription Glasses

Single vision, lined bifocal and lined trifocal lenses are covered.

Health plans may exclude cosmetic extras or any other items not necessary to correct vision, including:

- blended or progressive multi-focal lenses;
- oversize lenses; and/or
- tinted or coated lenses (other than solid pink #1 and #2).

c. Contact Lenses

When a Covered Person chooses contact lenses instead of glasses, costs associated with contact lenses are covered as if purchasing lenses for prescription glasses of equal value.

Health plans may exclude contact lenses that are solely for Cosmetic purposes (for example, to change eye color).

d. Related Professional Services

The following Professional services are covered when a Covered Person's annual vision exam (as described above) indicates that prescription glasses or contact lenses are necessary for proper vision:

- prescribe and order proper lenses;
- assist in the selection of a frame;
- verify the accuracy of the finished lenses;
- adjust and fit prescription glasses properly;
- perform necessary follow-up work; and/or
- adjust frames to maintain comfort and efficiency at a later date, if necessary.

e. Exclusions

In addition to any General Exclusions that may apply, health plans may exclude services or supplies for:

- vision training, orthoptics, or plano (non-prescription lenses);
- lenses and frames furnished under this program which are lost, broken, or scratched (these will only be replaced at the normal intervals when benefits are otherwise available);
- vision services for Covered Persons 21 years or older (except to the end of the Plan Year in which a Covered Person turns 21); or
- any eye exam or corrective eyewear required by an employer as a condition of employment.

37. Vision Services (Medical)

Services by an optometrist or ophthalmologist are covered in the same way as visits to providers performing otherwise covered eye care.

Health plans may condition coverage on an optometrist or ophthalmologist finding or reasonably suspecting a disease condition of the eye and making a referral to a Provider for treatment of that condition.

Health plans may exclude determinations of refractive state or any examination, prescription, or fitting of eyeglasses or contact lenses unless the refraction, examination, prescription, or fitting is for treatment of aphakia or keratoconus.

Health plans may limit coverage of lenses to replace the lens of the eye (for treatment of aphakia or keratoconus) to cover only one pair of lenses per prescription. Non-refractive therapeutic contact lenses are covered.

III. Conditions of Coverage and Exclusions

A. Conditions of Coverage

1. Medical Necessity

Health plans may limit coverage to services that are Medically Necessary for treatment of a Covered Person's condition. For the purposes of this EHB Benchmark, the terms "Medically Necessary" and "Medical Necessity" shall have the same meaning as in Regulation H-2011-02 § 4(Q).

2. Prior Approval

Except where expressly noted, health plans may require Prior Approval as a condition of coverage. For the purposes of this EHB Benchmark, the term "Prior Approval" has the same meaning as in 18 V.S.A. § 9418(15).

3. Provider Network

Except as required by law, health plans may limit coverage to Providers in the plan's network.

B. General Exclusions

In addition to the specific exclusions listed elsewhere, the following General Exclusions apply, which are not covered even if Medically Necessary.

- Services that a prior Health Plan must cover as extended benefits.

- Services for which a Covered Person would not legally have to pay without the health plan or similar coverage.
- Services for which there is no charge.
- Services paid directly or indirectly by a local, state, or federal government agency, except as otherwise provided by law.
- Services required because a Covered Person participated in a felony, riot, or insurrection.
- Services over the limitations or maximums set forth in the health plan.
- Services or drugs that the health plan determines are Investigational, mainly for research purposes or Experimental in nature. For purposes of this EHB, "Investigational" and "Experimental" services shall have the same meaning as in Regulation H-2011-02 § 4(H).
- Services not provided in accordance with accepted Professional medical standards in the United States.
- Services beyond those needed to establish or restore a Covered Person's ability to perform Activities of Daily Living (see Definitions), or to establish or re-establish the capability to perform occupational, hobby, sport, or leisure activities.
- Acupuncture, acupressure, or massage therapy; hypnotherapy, rolfing, homeopathic, or naturopathic remedies. (This exclusion does not apply to Medically Necessary services that would otherwise be Covered services when such services are performed by a naturopath and within the scope of the naturopathic Provider's license.)
- Electrical stimulation devices used externally. (This exclusion does not apply to bone growth stimulators, transcutaneous electrical nerve stimulation [TENS] devices, or neuromuscular electrical stimulators [NMES] for which a Covered Person has received Prior Approval.)
- Automatic or manual home blood pressure cuffs.
- Biofeedback or other forms of self-care or self-help training.
- Immunizations purchased in bulk, such as those provided to a group of people, and billed collectively rather than individually.
- Fluoride treatments performed in school.
- Whole blood, blood components, costs associated with the storage of blood, testing of blood the Covered Person donates for his or her own use (even if the blood is used), transfusion services for blood, and blood components the Covered Person donates for his or her own use in the absence of a Covered surgical procedure. (This exclusion does not apply to blood derivatives and transfusion services for whole blood, blood components, and blood derivatives.)
- Care for which there is no therapeutic benefit or likelihood of improvement.

- Care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the results of treatment, or the individual's medical progress.
- Clinical ecology, environmental medicine, Inpatient confinement for environmental change, or similar treatment.
- Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading, or writing skills.
- Communication devices and communication augmentation devices.
- Computer technology or accessories and other equipment, supplies, or treatment intended primarily to enhance occupational, recreational or vocational activities, hobbies, or academic performance.
- Annual, subscription, or retainer fees charged by concierge medicine practices.
- Consultations, including telephone consultations, except when they occur between Providers and the Providers attach a written report to the Covered Person's medical record.
- Correction of near- or far-sighted conditions or aphakia (where the lens of the eye is missing either congenitally or accidentally or has been surgically removed, as with cataracts) by means of "laser Surgery," or refractive keratoplasty procedures such as keratomileusis, keratophakia, and radial keratotomy and all related services.
- Cosmetic procedures and supplies that are not Reconstructive.
- Unless expressly required by law:
    - excision of excessive skin and subcutaneous tissue, and tightening (plication) of underlying structures (includes abdominoplasty, panniculectomy, correction of diastasis rectus, lipectomy, and umbilical transposition) of the chest, abdomen, thigh, leg, hip, buttocks, arm, forearm, hand, neck (submental fatpad), and all other areas not specified;
    - suction-assisted removal of fatty tissue (lipectomy) in the head, neck, trunk, upper extremity, or lower extremity;
    - breast lift (mastopexy) except when a necessary component of reconstruction of breasts following breast Surgery;
    - repair of brow ptosis, repair of blepharoptosis, correction of lid retraction, reduction of overcorrection of lid ptosis; and/or
    - Surgery to improve the appearance of the ear (otoplasty) and the nose (rhinoplasty); This exclusion does not apply to abdominoplasty or panniculectomy when abdominoplasty and/or panniculectomy is performed in connection with herniorrhaphy (hernia repair). This exclusion also does not apply to lipectomy performed as part of the treatment of lipedema.
- Custodial Care and Rest Cures.

- Dental services and dental-related oral Surgery, unless specifically provided by the health plan; procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants, and ramus mandibular stapling).
- Any determination of refractive state or any examination, prescription or fitting of eyeglasses or contact lenses unless the refraction, examination, prescription, or fitting is for treatment of aphakia or keratoconus.
- Education, educational evaluation or therapy, therapeutic boarding schools, services that should be Covered as part of an evaluation for, or inclusion in, a Child's individualized education plan (IEP) or other educational program.
- Routine foot care services.
- Home or automobile modifications or equipment like air conditioners, HEPA filters, humidifiers, stair glides, elevators, lifts, motorized scooters, whirlpools, furniture, or "barrier-free" construction, even if prescribed by a Provider.
- Hot and cold packs.
- Illnesses or injuries that are:
    - a result of an act of war (declared or undeclared); or
    - sustained in active military service.
- Infertility services, except evaluations to determine if and why a couple is infertile. This includes, but is not limited to:
    - medications for treatment of infertility such as Clomid, Clomiphene, Serophene, Bravelle, Gonal-F, Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi, and Repronex when used for treatment of infertility; and
    - surgical, radiological, pathological, or laboratory procedures leading to or in connection with (for example):
        - insemination (intravaginal, intracervical, and intrauterine insemination);
        - in vitro fertilization, embryo transplantation, and gamete intrafallopian transfer (GIFT);
        - zygote intrafallopian transfer (ZIFT); and
        - any variations of these procedures, including costs associated with collection, washing, preparation, or storage of sperm for artificial insemination including donor fees, cryopreservation of donor sperm and eggs.
- An Inpatient stay determined not Medically Necessary while a Covered Person is waiting for a different level of care, such as Skilled Nursing Facility or home care, whether or not it is available.
- Treatment for willfully uncooperative or intractable patients.
- Institutional or Custodial Care for the physically or mentally handicapped.

- Mandated treatment, including court-ordered treatment, unless such treatment is Medically Necessary, ordered by a Provider and covered by the health plan.
- Non-medical charges, such as:
    - taxes;
    - postage, shipping and handling charges;
    - charges for Home Health Medical Social Work visits;
    - a penalty for failure to keep a scheduled visit; or
    - fees for copies of medical records, transcripts, or completion of a claim form.
- Orthodontics, including orthodontics performed as adjunct to orthognathic Surgery or in connection with accidental injury, unless otherwise covered by the health plan.
- Personal hygiene items.
- Personal service, comfort, or convenience items.
- Photography services, photographic supplies or film development supplies or services (for example, external ocular photography or photography of moles to monitor changes).
- Physical fitness equipment, braces and devices intended primarily for use with sports or physical activities other than Activities of Daily Living (e.g., knee braces for skiing, running, or hiking); weight loss or exercise programs; health club or fitness center memberships.
- Pneumatic cervical traction devices except when the patient has a diagnosis of Temporomandibular Joint Syndrome (TMJ); gravity assisted traction devices.
- Services, including modalities, that do not require the constant attendance of a Provider.
- Specialized examinations, services or supplies required by an employer or for sports/recreational activities (e.g. driver certifications, pilot flight physicals, etc.).
- Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).
- Supervised services or modalities that do not require the skill and expertise of a licensed Provider.
- Support therapies, including pastoral counseling, assertiveness training, dream therapy, equine therapy, hippotherapy, music or art therapy, recreational therapy, stress management, wilderness programs, therapy camps, retreat centers, adventure therapy, and bright light therapy. This includes non-medical tobacco cessation programs, such as hypnotherapy and other alternative approaches for tobacco cessation.
- Travel (other than Ambulance transport), lodging and housing (when it is not integral to a Medically Necessary level of care, even if prescribed by a Provider).
- Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport, or leisure activities.
- Treatment of obesity, except surgical treatment when determined Medically Necessary.

- Unattended services or modalities (application of a service or modality) that do not require direct one-on-one patient contact by the Provider.
- Vision training, orthoptics, or plano (non-prescription lenses).
- Work-hardening programs and work-related illnesses or injuries (or those which may be work-related, until otherwise finally adjudicated), provided such illnesses or injuries are covered by workers' compensation or should be so covered. (This provision does not require an individual, such as a sole proprietor or an owner/partner to maintain worker's compensation coverage if they are not legally required to be covered.)

C. Provider Exclusions

This EHB Benchmark does not provide coverage for services prescribed or provided by a:

- Provider that the health plan does not approve for a given service or that does not meet the definition of "Provider" below.
- Professional who provides services as part of his or her education or training program.
- Immediate Family Member or the Covered Person.
- Veterans Administration Facility treating a service-connected disability.
- Provider practicing outside the scope of that Provider's license or certification.

Appendix

A. Vermont State Mandates

Fully insured health plans in Vermont must provide the following care, treatment, and services:

Service or Benefit Description	Statutory or Regulatory Reference
Outpatient contraceptive services, including sterilizations.	8 V.S.A. § 4099c
Home health care services.	8 V.S.A. § 4096
Emergency services.	Rule H-2009-03
Maternity services.	Rule I-1989-01
Evidence-based diagnosis and treatment of early childhood developmental disorders.	8 V.S.A. § 4088i
Chiropractic services.	8 V.S.A. § 4088a
Prosthetic devices.	8 V.S.A. § 4088f
Breast cancer screening.	8 V.S.A. § 4100a
Pediatric vaccine services.	8 V.S.A. § 4100d
Prostate cancer screenings.	8 V.S.A. § 4100f
Colorectal cancer screenings.	8 V.S.A. § 4100g
Chemotherapy treatment (Medically Necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen).	8 V.S.A. § 4088c
Clinical trials for cancer patients.	8 V.S.A. § 4088b
Diabetes treatment services.	8 V.S.A. § 4089c
Off-label use of prescription drugs for cancer.	8 V.S.A. § 4100e
Anesthesia for dental procedures performed on certain Covered Persons.	8 V.S.A. § 4100i
Mental health and substance use disorder parity (prohibition on the establishment of any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental condition than for access to treatment for other health conditions).	8 V.S.A. § 4089b
Orally administered anti-cancer medications.	8 V.S.A. § 4100h
Tobacco cessation medications.	8 V.S.A. § 4100j
Diagnosis and Medically Necessary treatment of craniofacial disorders.	8 V.S.A. § 4089g
Medical foods prescribed for Medically Necessary treatment for an inherited metabolic disease.	8 V.S.A. § 4089e
Naturopathic services.	8 V.S.A. § 4088d
Athletic trainer services.	8 V.S.A. § 4088g
Sexual assault examinations for victims of alleged sexual assault.	8 V.S.A. § 4089

Coverage of newly born children.	8 V.S.A. § 4092

Vermont law also imposes substantial non-discrimination obligations on fully insured plans. 8 V.S.A. § 4724(7).

B. Definitions

Activities of Daily Living: includes eating, toileting, transferring, bathing, dressing, and mobility.

Acute (Care): (treatment of) an illness, injury, or condition, marked by a sudden onset or abrupt change of the Covered Person's health status that requires prompt medical attention. Acute Care may range from Outpatient evaluation and treatment to intensive Inpatient care. Acute Care is intended to produce measurable improvement, to arrest, if possible, natural deterioration from illness or injury or to obtain Rehabilitative potential within a reasonable and medically predictable period of time. Acute Care should be provided in the least restrictive setting. Acute services means services which, according to generally accepted Professional standards, are expected to provide or sustain significant, measurable clinical effect within a reasonable and medically predictable period of time.

Ambulance: a specially designed and equipped vehicle for transportation of the sick and injured.

Chiropractor: a duly licensed doctor of chiropractic, acting within the scope of his or her license to treat and prevent neuromusculoskeletal disorders.

Chronic Care: health services provided by a health care Professional for an established clinical condition that is expected to last three months or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions. Examples of chronic conditions include anxiety disorder, asthma, bipolar disorder, COPD, diabetes, heart disease, major depression, post-traumatic stress disorder, schizophrenia, and substance use disorder.

Cosmetic: primarily intended to improve appearance.

Cost-Sharing: any costs for Covered services that are paid "out of pocket" by the Covered Person, including deductibles, co-payments, and coinsurance.

Covered: describes a service or supply for which a Covered Person is eligible for health insurance benefits.

Covered Person: an individual enrolled in a health plan.

Custodial Care: services primarily designed to help in daily living activities. Custodial Care includes, but is not limited to:

- help in walking, bathing and other personal hygiene, toileting, getting in and out of bed;
- dressing;
- feeding;
- preparation of special diets;
- administration of oral medications;
- care not requiring skilled Professionals;
- Child care;
- adult day care;
- Domiciliary Care (as further defined herein);
- care solely to comply with a court order, to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite, unless such care is Medically Necessary;
- housing that is not integral to a Medically Necessary level of care.

Covered: describes a service or supply for which a Covered Person is eligible for health insurance benefits.

Domiciliary Care: services in the home or in a home-like environment if the Covered Person is unable to live alone because of demonstrated difficulties:

- in accomplishing Activities of Daily Living;
- in social or personal adjustment; or
- resulting from disabilities that inhibit personal care.

Durable Medical Equipment (DME): has the same meaning as 42 C.F.R. § 414.202.

Facility or Health Care Facility: has the same meaning as 18 V.S.A. § 9402(6).

Habilitative/Rehabilitative: Habilitative and Rehabilitative services are health care services and devices provided to achieve normal functions and skills necessary to perform age-appropriate basic Activities of Daily Living, including ambulation, eating, bathing, dressing, speech, and elimination.

- Habilitation and Rehabilitation services may include respiratory therapy, speech language therapy, Occupational Therapy, and physical medicine treatments.

- Habilitative services and devices help a person attain a skill or function never learned or acquired due to a disabling condition. Rehabilitative services and devices, on the other hand, help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

Health Plan: has the same meaning as in 33 V.S.A. § 1811(a)(1).

Hospice: an organization engaged in providing care to the terminally ill. It must be federally certified to provide Hospice services or accredited as a Hospice by the Joint Commission on Accreditation of Healthcare Organizations.

Immediate Family Member: a Spouse (or spousal equivalent), parent, grandparent, Child, sibling, parent-in-law, son/daughter-in-law, brother/sister-in-law, step-parent, step-Child, stepsibling, or any other person who is permanently residing in the same residence as the Covered Person. The listed familial relationships do not require residing in the same residence.

Inpatient: care at a Facility for a patient who is admitted and incurs a room and board charge.

Intensive Outpatient Programs: programs that have the capacity for planned, structured service provision of at least two hours per day and three days per week. The services offered address mental health or substance use disorders and could include group, individual, family, or multi-family group psychotherapy, psychoeducational services and adjunctive services such as medical monitoring. These services would include multiple or extended treatment, Rehabilitation or counseling visits or Professional supervision and support.

Occupational Therapy: therapy that promotes the restoration of a physically disabled person's ability to accomplish the ordinary tasks of daily living or the requirements of the person's particular occupation. Occupational Therapy must include constructive activities designed and adapted for a specific condition.

Off-label Use of a Drug: use of a drug for other than the particular condition for which the Food and Drug Administration gave approval.

Outpatient: a patient who receives services from a Professional or Facility while not an Inpatient.

Palliative: intended to relieve symptoms (such as pain) without altering the underlying disease process.

Physical Rehabilitation Facility: a Facility that primarily provides Rehabilitation services on an Inpatient basis. Care consists of the combined use of medical, pharmacy, social, educational and vocational services. These services enable patients disabled by disease or injury to achieve continued improvement of functional ability. Services must be provided by or under the supervision of Providers. Nursing services must be provided under the supervision of registered nurses (RNs).

Physical Therapy: therapy that relieves pain of an Acute condition, restores function and prevents disability following disease, injury or loss of body part.

Physician: a doctor of medicine (includes psychiatrists) or osteopathy, dental Surgery, medical dentistry, or naturopathy.

Plan Year: the year beginning on the date when Deductibles, Out-of-Pocket Limits, and other totals begin to accumulate.

Prescription Drugs and Biologics: products that are:

- prescribed to treat, prevent, or diagnose a medical condition;
- FDA-approved (or not FDA-approved if the use meets the definition of Medical Necessity and is not considered Investigational); and
- approved by the health plan for reimbursement for the specific medical condition being treated or diagnosed, or as otherwise required by law.

Preventive Services: services used to find or reduce risks when there are no symptoms, signs, or specific increased risk for the condition being targeted. They may include immunizations, screening, counseling or medications that can prevent or find a condition.

Professional: one of the following practitioners:

- athletic trainers
- audiologists
- Chiropractors
- mental health Professionals:
    - clinical mental health counselors
    - clinical psychologists
    - clinical social workers
    - marriage and family therapists
    - psychiatric nurse practitioners
- nurses:
    - certified nurse midwives or licensed Professional midwives
    - certified registered nurse anesthetists
    - lactation consultants
    - licensed practical nurses (LPNs)
    - nurse practitioners
    - registered nurses (RNs)
- nutritional counselors
- optometrists

- podiatrists
- Providers
- substance use disorder counselors
- therapists (Occupational, Physical and Speech)

Provider: a Facility, Professional, or Other Provider who is:

- approved by the health plan;
- licensed and/or certified where required; and
- acting within the scope of that license and/or certification.

Residential Treatment Center: a Facility that is licensed at the residential intermediate level or as an intermediate care Facility (ICF) and provides Residential Treatment Program services.

Residential Treatment Program: a 24-hour level of care that provides patients with long-term or severe mental disorders or substance use disorders with residential care. Care is medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. Care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential care also includes training in the basic skills of living as determined necessary for each patient.

Respite Care: care that relieves family members or caregivers by providing temporary relief from the duties of caring for covered terminally ill patients.

Rest Cure: treatment by rest and isolation such as, but not limited to, hot springs or spas.

Skilled Nursing Facility: a Facility that primarily provides 24-hour Inpatient skilled nursing care and related services delivered or directed by Providers. Facilities must keep permanent medical history records.

Specialty Drugs or Medications: injectable and non-injectable drugs with key characteristics, including (but not limited to): frequent dosing adjustments and intensive clinical monitoring; intensive patient training and compliance assistance; limited product availability, specialized product handling and administration requirements.

Speech Therapy (Speech-Language Pathology): Speech-Language Pathology (SLP) services are the treatment of swallowing, speech-language, and cognitive- communication disorders. SLP services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation.

Supportive Care: services provided for a known relapsing or recurring condition to prevent an exacerbation of symptoms that would require additional services to restore an individual to his or her usual state of health or to prevent progressive deterioration.

Surgery: generally accepted invasive, operative and cutting procedures. Surgery includes:

- specialized instrumentations;
- some shots, allergy and other;
- endoscopic examinations;
- treatment of burns;
- correction of fractures and dislocations; and
- anesthesia and the administration of anesthetics to get general or regional (but not local) muscular relaxation, loss of sensation or loss of consciousness.