Vermont...

Department of Banking, Insurance and Securities

ORIGINAL

August 5, 1993

BULLETIN 102

ACT 52 COMMON HEALTH CARE PLAN

As of July 30, 1993, I have approved two common health care plans, pursuant to Title 8 V.S.A. §4080a and Regulation 91-4b. The two plans are entitled "Act 52 Insurance Plan I" and "Act 52 Insurance Plan II." The plans share identical benefits, but have different deductibles and out-of-pocket limits. Small group carriers must make these two plans available to consumers no later than February 1, 1994. Questions or concerns regarding the filing of rates and forms for these two plans should be addressed to Lyle Moulton, Senior Health Analyst. Registered small group carriers should follow the guidelines set forth in Regulation 91-4a for the approval of community rates and rating methodology.

Very truly yours,

Elizabeth R. Costle
Commissioner

lmw

89 Main St., Drawer 20, Montpelier, VT 05620-3101
Banking, Insurance Divisions: (802) 828-3301; Securities Division: (802) 828-3420

ACT 52 INSURANCE PLAN I

OUTLINE OF COVERAGE

POLICY NUMBER - 999-99-9999
MEMBERSHIP TYPE - 1P/2P/FAMILY
PREMIUM PAYMENT -
GROUP NUMBER/NAME - 12345-678
COMMON INDUSTRY, INC.

EMPLOYEE NAME AND ADDRESS
JOHN J. DOE
APARTMENT 15-B
19 MAPLE AVENUE
MANAGED CARE, VT 05699-1234

THE MAXIMUM YOU MUST PAY TOWARD:

ANNUAL DEDUCTIBLE

INDIVIDUAL	- $ 150
TWO-PERSON	- $ 300
FAMILY	- $ 450

OUT-OF-POCKET LIMIT

INDIVIDUAL	- $ 500
TWO-PERSON	- $1,000
FAMILY	- $1,500

COVERAGE IS SUBJECT TO THE FOLLOWING INDIVIDUAL BENEFIT MAXIMUMS:

COMPREHENSIVE CERTIFICATE

LIFETIME . . . . . - $1,000,000 /LIFETIME

TRANSPLANT AGGREGATE . . . . . - $1,000,000 /LIFETIME

MENTAL HEALTH - INPATIENT . . . - 45 /DAYS/YEAR PAYABLE AT 80%

- OUTPATIENT . . - 40 /VISITS/YEAR PAYABLE AT 80%

YOUR PORTION OF COVERED CHARGES FOR COVERED SERVICES

	COINSURANCE	
AMBULANCE	20%	
*CARDIAC REHABILITATION	20%	
*DENTAL	20%	
*DIAGNOSTIC	20%	
*GENERAL HOSPITAL	20%	
*HOME CARE	20%	
*HOSPICE CARE	20%	
*MATERNITY	20%	
PRE-NATAL CARE	0%	- SEE PREVENTIVE CARE
*MEDICAL EQUIPMENT/SUPPLIES	20%	
*MEDICAL CARE	20%	
*MENTAL HEALTH		
INPATIENT	20%	
OUTPATIENT (40 VISITS)	20%	
*PHYSICAL REHAB FACILITY	20%	
PRESCRIPTION DRUGS	20%	
PREVENTIVE CARE	0%	- UP TO $150, THEN 20% THEREAFTER
*SKILLED NURSING FACILITY	20%	
*SUBSTANCE ABUSE REHAB FACILITY	20%	
*SURGICAL	20%	
*THERAPY	20%	
*TRANSPLANTS	20%	

DEDUCTIBLES APPLY TO ALL SERVICES EXCEPT FOR PREVENTIVE CARE
SEE ARTICLE III FOR COVERED SERVICES

* YOU MUST RECEIVE **ADMISSION REVIEW OR PRIOR APPROVAL** FROM US FOR SPECIFIC SERVICES AS DEFINED IN YOUR POLICY OR LISTED ON THIS OUTLINE OF COVERAGE.

ACT 52 INSURANCE PLAN II

OUTLINE OF COVERAGE

POLICY NUMBER	- 999-99-9999	**EMPLOYEE NAME AND ADDRESS**
MEMBERSHIP TYPE	- 1P/2P/FAMILY	JOHN J. DOE
PREMIUM PAYMENT	-	APARTMENT 15-B
GROUP NUMBER/NAME	- 12345-678	19 MAPLE AVENUE
	COMMON INDUSTRY, INC.	MANAGED CARE, VT 05699-1234

THE MAXIMUM YOU MUST PAY TOWARD:

ANNUAL DEDUCTIBLE

INDIVIDUAL	- $ 500
TWO-PERSON	- $ 1000
FAMILY	- $ 1500

OUT-OF-POCKET LIMIT

INDIVIDUAL	- $1,000
TWO-PERSON	- $2,000
FAMILY	- $3,000

COVERAGE IS SUBJECT TO THE FOLLOWING INDIVIDUAL BENEFIT MAXIMUMS:

COMPREHENSIVE CERTIFICATE

LIFETIME . . . . . - $1,000,000 /LIFETIME

TRANSPLANT AGGREGATE . . . . . - $1,000,000 /LIFETIME

MENTAL HEALTH - INPATIENT . . . - 45 /DAYS/YEAR PAYABLE AT 80%

- OUTPATIENT . . - 40 /VISITS/YEAR PAYABLE AT 80%

YOUR PORTION OF COVERED CHARGES FOR COVERED SERVICES

	COINSURANCE	
AMBULANCE	20%	
*CARDIAC REHABILITATION	20%	
*DENTAL	20%	
*DIAGNOSTIC	20%	
*GENERAL HOSPITAL	20%	
*HOME CARE	20%	
*HOSPICE CARE	20%	
*MATERNITY	20%	
PRE-NATAL CARE	0%	- SEE PREVENTIVE CARE
*MEDICAL EQUIPMENT/SUPPLIES	20%	
*MEDICAL CARE	20%	
*MENTAL HEALTH		
INPATIENT (45 DAYS/YEAR)	20%	
OUTPATIENT (40 VISITS/YEAR)	20%	
*PHYSICAL REHAB FACILITY	20%	
PRESCRIPTION DRUGS	20%	
PREVENTIVE CARE	0%	- UP TO $150, THEN 20% THEREAFTER
*SKILLED NURSING FACILITY	20%	
*SUBSTANCE ABUSE REHAB FACILITY	20%	
*SURGICAL	20%	
*THERAPY	20%	
*TRANSPLANTS	20%	

DEDUCTIBLES APPLY TO ALL SERVICES EXCEPT FOR PREVENTIVE CARE
SEE ARTICLE III FOR COVERED SERVICES

* YOU MUST RECEIVE **ADMISSION REVIEW OR PRIOR APPROVAL** FROM US FOR SPECIFIC SERVICES AS DEFINED IN YOUR POLICY OR LISTED ON THIS OUTLINE OF COVERAGE.

VERMONT
ACT 52 INSURANCE PLAN

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ARTICLE I
DEFINITIONS

The following terms have special meanings in this contract. The usage of these terms is very important for you to clearly understand this contract. These terms are not capitalized in this contract for ease of reading. Words used often in this contract are defined in this article. Other words are defined where used in the text.

ACUTE CARE treats illnesses, injuries or conditions marked by a sudden onset or abrupt change of status requiring prompt medical attention. Acute care may include hospitalization of limited duration. Acute care produces measurable improvement or maximum rehabilitative potential within a reasonable and medically predictable period of time.

ADMISSION REVIEW is our determination of whether your unscheduled inpatient admission is medically necessary for:

- an emergency condition;
- a maternity condition; or
- a condition requiring an extended hospital stay of a newborn.

ANESTHESIA---the administration of anesthetics to obtain:

- general or regional (but not local) muscular relaxation;
- loss of sensation; or
- loss of consciousness.

ASSISTANT SURGEON is a physician or physician's assistant (PA) who actively assists the operating surgeon in performing surgery.

ATTENDING PHYSICIAN is the physician responsible for your overall care and direction of treatment.

BENEFIT is the amount we pay for a service as shown on your explanation of benefits.

BIRTHING CENTER is an alternative birthing facility with a certified nurse midwife or physician providing care.

CHILD is a covered employee's:

- unmarried son, daughter or stepchild;
- legally adopted child (including a child living with the adoptive parents during the period of probation); or
- child for whom the covered employee is legal guardian.

A child must live in the covered employee's household unless (s)he is a full-time dependent student. A child must be under 19 years of age or a full-time dependent student under 25 years of age.

CHRONIC CARE treats an illness, injury or condition that does not require hospitalization. Chronic care may:

- require confinement in an alternative facility (i.e. nursing home);
- be expected to be of long duration without any reasonably predictable date of termination; and
- be marked by reoccurrences requiring acute care on a continuous or periodic basis.

COINSURANCE is the amount **you must pay** after you meet your deductible for services shown on your outline of coverage.

COMMUNITY MENTAL HEALTH FACILITY provides mental health services. Examples of these facilities include:

- hospitals;
- outpatient psychiatric clinics;
- day treatment centers; and
- community mental health centers.

A community mental health facility must be approved by the Secretary of the Agency of Human Services.

CONSULTATION is a review by a professional provider whom your attending physician asks to give professional advice about your condition.

CONTINUED STAY REVIEW is our review to determine if your continued hospitalization is medically necessary.

CONTRACT consists of:

- the documents listed on your outline of coverage;
- your identification card; and
- your application and any supplemental applications submitted by you and approved by us.

CO-PAYMENT is the fixed dollar amount **you must pay** for specific services, if any, as shown on your outline of coverage.

COSMETIC SURGERY is surgery primarily intended to improve appearance.

COVERED EMPLOYEE is the individual with whom we have entered into this contract or on whose behalf the group has entered into this contract.

COVERED SERVICE is a service or supply eligible for benefits under this contract.

CUSTODIAL CARE is primarily for maintenance or designed to help in your daily living activities. Custodial care is not primarily provided for its medical value. Custodial care includes, but is not limited to:

- help in walking, bathing, dressing and feeding;
- preparation of special diets;
- supervision over administration of medications; and
- care not requiring skilled nursing services.

DEDUCTIBLE is the amount **you must pay** toward the cost of specific services before we pay any benefits. Deductible amounts are shown on your outline of coverage.

DEPENDENT is a covered employee's spouse or child covered under this contract.

DURABLE MEDICAL EQUIPMENT (DME) is equipment:

- prescribed by your 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 without illness or injury.

DME **includes**, but is not limited to: wheelchairs, hospital-type beds, walkers, traction equipment and respirators.

DME **does not include** items such as: air conditioners, dehumidifiers, whirlpool baths, exercise equipment and other equipment that has both non-medical and medical uses.

EMERGENCY ACCIDENT CARE is emergency treatment of traumatic bodily injuries resulting from an accident.

EMERGENCY MEDICAL CARE is emergency services provided after the sudden onset of a medical condition. The patient must exhibit acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to:

- place the patient's health in serious jeopardy;
- cause serious impairment to bodily functions; or
- cause serious dysfunction of any bodily organ.

EXPERIMENTAL or INVESTIGATIONAL (DRUG, DEVICE AND MEDICAL TREATMENT OR PROCEDURE): a drug, device or medical treatment or procedure is experimental or investigational :

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- if the drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, the device, treatment or procedure, was reviewed and approved by the treating facilities' Institutional Review Board or other body serving similar function, or if federal law requires such review and approval; or
- if reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
- if reliable evidence shows that the prevailing opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

FACILITY PROVIDER is one of the following institutions or entities:

- Ambulatory Surgical Center
- * Birthing Center
- * General Hospital
- * Home Health Agency/Visiting Nurse Association/Private Duty Nurse
- * Physical Rehabilitation Facility
- * Skilled Nursing Facility
- * Substance Abuse Rehabilitation Facility
- * Psychiatric Hospital

* Facilities further defined in this article.

GENERAL HOSPITAL is a short-term, acute care hospital that:

- is a duly licensed institution;
- primarily provides diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick persons by or under the supervision of physicians;
- has organized departments of medicine and major surgery; and
- provides 24-hour nursing service by or under the supervision of registered nurses.

GROUP is an individual, firm, association or corporation that has agreed to forward to us or through a remitting agent premiums due under this contract.

HOME HEALTH AGENCY/VISITING NURSE ASSOCIATION is an organization that brings skilled nursing and other services into your home. It must be certified under Title 18 of the Social Security Act, as amended.

INDEPENDENT CLINICAL LABORATORY performs clinical procedures and is not associated with a facility or professional provider.

INDIVIDUAL CASE BENEFIT MANAGEMENT is our review to determine if an alternative setting or treatment would be appropriate for

your condition. We provide benefits for alternative settings or treatment even if we do not cover them under this contract. Our decision to provide benefits for alternative care in one case shall not obligate us to provide the same benefits again to you or any other person covered under this contract.

INPATIENT is a patient at a facility provider for whom the facility charges room and board. We compute the length of an inpatient stay by counting either the day of admission or discharge, but not both.

MEDICAL CARE is care by a professional provider for treatment of an illness or injury.

MEDICALLY NECESSARY (MEDICAL NECESSITY) is our determination of whether services or supplies are:

- appropriate for the symptoms, diagnosis or treatment of your condition, illness, disease or injury;
- provided for the diagnosis or direct care and treatment of your condition, illness, disease or injury;
- in accordance with standards of good medical practice;
- not primarily for your or your provider's convenience; and
- the most appropriate supply or level of service that can safely be provided to you.

Even though a provider prescribes, performs, orders, recommends or approves a service, this does not connote medical necessity. The final determination of medical necessity rests with us.

MEDICAL/SURGICAL SUPPLIES include, but are not limited to: syringes, dressings, catheters, colostomy bags and oxygen. These supplies are used for medical purposes only.

OUTLINE OF COVERAGE is a summary of your contract benefits.

OUT-OF-POCKET LIMIT(S) is the maximum amount of deductibles plus coinsurance you must pay during a calendar year. After you have satisfied your out-of-pocket limit, you are no longer required to pay coinsurance during the remainder of that calendar year.

OUTPATIENT is any setting where you receive services or supplies while not an inpatient.

PHYSICAL REHABILITATION FACILITY primarily provides rehabilitation care services on an inpatient basis. Care consists of the combined use of medical, 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 physicians. Nursing services must be provided under the supervision of registered nurses.

PHYSICIAN is a doctor of medicine, dental surgery, medical dentistry or osteopathy.

PRE-ADMISSION REVIEW is our review to determine if your scheduled inpatient admission is medically necessary.

PRE-EXISTING CONDITION is a condition for which:

- medical advice or treatment was recommended by or received from a professional provider within a one year period preceding your continuous coverage with us, or
- the existence of symptoms that would cause a prudent person to seek diagnosis, care or treatment within a one year period preceding your continuous coverage with us.

Benefits for pre-existing conditions will be paid after a person has been insured under this plan for 12 months in a row.

EXCEPTIONS - Pre existing conditions will be waived for all new employees or members, and their dependents, who produce evidence of continuous health benefit coverage during the previous nine months substantially equivalent to this plan.

PRIOR APPROVAL is the required written approval that you must obtain from us before you receive specific services noted in this contract. **If you do not obtain written approval from us before you receive services, benefits may be reduced.**

PROFESSIONAL PROVIDER is a practitioner only as listed:

- Audiologist
- Certified Substance Abuse Counselor
- Independent Clinical Laboratory
- Mental Health Professionals:
  - Clinical Psychologist
  - Clinical Social Worker
  - Clinical Mental Health Counselor
  - Psychiatric Nurse Practitioner
- Nurses:
  - Certified Registered Nurse Anesthetist (CRNA)
  - Licensed Practical Nurse (LPN)
  - Nurse Practitioner
  - Nurse Midwife (CNM)
  - Registered Nurse (RN)
- Optometrists
- Physician (including Dentists and Psychiatrists)
- Podiatrist
- Therapists (Occupational, Physical and Speech)

PROVIDER is a facility provider, professional provider or other provider:

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

PSYCHIATRIC HOSPITAL provides diagnostic and therapeutic facilities for the diagnosis, treatment and acute care of mental and personality disorders. Care must be directed by a staff of physicians. A psychiatric hospital must:

- provide 24-hour nursing service by or under the supervision of registered nurses (RN);
- keep permanent medical history records; and
- be a private psychiatric or public mental hospital approved by the Secretary of the Agency of Human Services.

RECONSTRUCTIVE SURGERY corrects deformities resulting from birth, injury or disease, or that are medically necessary following injury or disease.

SKILLED NURSING FACILITY primarily provides inpatient skilled nursing care and related services. Care requires 24-hour skilled nursing services but does not require confinement in a general hospital. Physicians provide or direct services. Facilities must keep permanent medical history records. The facility is not, other than occasionally, a place that provides:

- minimal care, custodial care, ambulatory care, or part-time care services;
- care or treatment of mental illness, substance abuse or pulmonary tuberculosis; or
- rehabilitation.

SPOUSE is the covered employee's spouse under a legally valid marriage between persons of the opposite sex.

SUBSTANCE ABUSE is any use of alcohol or drugs that produces a pattern of behavior causing:

- impairment in social or occupational functioning; or
- physiological dependency evidenced by physical tolerance or withdrawal.

SUBSTANCE ABUSE REHABILITATION FACILITY primarily provides rehabilitation treatment for substance abuse. Treatment must follow a written plan. Facilities must be approved by the Secretary of the Agency of Human Services.

SURGERY is a generally accepted invasive, operative and cutting procedures. This includes, but is not limited to:

- specialized instrumentations;
- endoscopic examinations;
- treatment of burns; and
- correction of fractures and dislocations.

THERAPY SERVICES include, but are not limited to the following treatments:

Radiation therapy treats disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Chemotherapy prevents the development, growth, or multiplication of malignant diseases by chemical or biological agents.

Dialysis removes waste materials when a patient has acute kidney failure or chronic irreversible kidney deficiency.

Physical therapy relieves pain of an acute condition; restores function; and prevents disability following disease, injury or loss of body part.

Occupational therapy promotes the restoration of a physically disabled person's ability:

- to accomplish the ordinary tasks of daily living; and
- to accomplish the ordinary tasks required by the person's particular occupation.

Therapy uses constructive activities designed and adapted for each specific condition.

Speech therapy tries to correct speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies or previous curative processes.

Infusion therapy treats disease conditions by continuous injection of curative agents. Treatment may be given by a facility provider or self-administered.

Inhalation therapy uses inhalation of medicine, water vapor and/or gases to treat impaired breathing.

TOTAL CHARGE is the total amount charged by the provider for a service.

YOU, YOUR is the covered employee and any dependents covered under this contract.

WE, US, OUR is the insurer or any designated agent(s) of the insurer.

ARTICLE II
MANAGED BENEFIT PROGRAM

PROGRAM GOALS

The goals of this program are:

- to contain health care costs;
- to provide health care services in settings that best meet your needs; and
- to acquaint you with treatment options.

In order to meet these goals, **we require you** to contact us for:

- pre-admission review: and
- admission review.

Your **health care coverage may be limited** if you do not comply with the requirements outlined below. Even if this coverage is secondary to other coverage available to you from another health insurance provider, you must comply with the Managed Benefit Program.

Also, in order to meet these goals, we may, at our discretion, use:

- individual case benefit management; and
- continued stay review.

PROGRAM REQUIREMENTS

Pre-admission Review---Non Emergency and Maternity Conditions

You must contact us for **prior approval** before a scheduled inpatient admission. You must also notify us if your admission or service date is changed. We recommend that you contact us two weeks before the admission or service date.

Admission Review---Emergency and Maternity Conditions

You must contact us within 48 hours (or as soon as reasonably possible) after an emergency or maternity admission. You must also contact us within 48 hours (or as soon as reasonably possible) after the mother's discharge if the newborn stays in the hospital. Note: A family member, attending physician or facility may contact us. However, it is ultimately your responsibility to ensure that notification is timely.

BENEFIT REDUCTION FOR NON-COMPLIANCE

Your benefits may be reduced if you do not meet the above program requirements as follows:

Pre-admission Review or Admission Review

You will be responsible for a portion of the inpatient charges equal to **$500.00** per admission.

ARTICLE III
COVERED SERVICES

This article explains your coverage. All benefits are subject to the exclusions, conditions and limitations cited in this contract.

Remember, you are only eligible for benefits if:

- your treatment, intervention or other service is medically necessary;
- your treatment, intervention or other service is a covered service;
- you receive services from a professional provider;
- you meet the **Managed Benefit Program** requirements, which include:
  - **prior approval** before scheduled inpatient admissions; and
  - **admission review** after an emergency or maternity admission;
- you obtain **prior approval** for services specified in this article; and
- your treatment, intervention or other service is not as a result of **pre-existing condition**, as defined.

AMBULANCE SERVICES

Benefits---Transportation of the sick and injured, by air or land:

- to a general hospital from your home, scene of accident or scene of medical emergency;
- between general hospitals; or
- between a general hospital and skilled nursing facility.

Requirements---The ambulance must be a specially designed and equipped vehicle for transportation of the sick and injured.

Limitations---We only provide benefits for your transportation to the closest facility that can provide services appropriate for the treatment of your condition.

Exclusions---We provide no benefits if you could have been transported in a private car.

CARDIAC REHABILITATION SERVICES

Definitions---

Cardiac rehabilitation is for a **cardiac event** related to an acute coronary artery disease. An acute cardiac event includes, but is not limited to:

- a myocardial infarction; or
- a coronary artery bypass graft or coronary angioplasty, resulting in maximum functional capacity at 3 weeks post-event of less than 8 METS (Metabolic Energy Equivalent).

Benefits---Supervised exercise sessions up to 3 sessions per week and up to a total of 18 sessions for each cardiac event.

Requirements---We only provide benefits if:

- a cardiac rehabilitation provider performs the services;
- you obtain **prior approval**; and
- your condition meets our medical eligibility requirements as we determine from time-to-time.

DENTAL SERVICES

Benefits---

- temporomandibular joint syndrome;
- accidental injury to the jaws, sound natural teeth, mouth or face occurring on or after your membership effective date;
- oral surgery required to correct gross deformity resulting from major disease or surgery;
- surgical removal of bone-impacted teeth;
- gingivectomy only for specific conditions defined by us; and
- care resulting from medical necessity.

Requirements---We require **prior approval** for:

- dental services resulting from accidental injury to sound natural teeth beyond six months following an accident;
- oral surgery required to correct gross deformity; and
- medically necessary dental care.

Exclusions---We provide no benefits for:

- any dental services performed by other than a physician, as defined;
- care for periodontitis;
- repair or replacement of damaged dental prosthesis;
- injury as a result of chewing or biting; and
- dental care not specified as a benefit above.

DIAGNOSTIC SERVICES

Benefits---Diagnostic services to determine a definite condition or disease, ordered by a provider, include, but are not limited to:

- imaging (radiology, ultrasound and nuclear);
- studies of the nature and cause of disease (laboratory and pathology tests);
- medical procedures (ECG and EEG); and
- allergy testing (percutaneous, intracutaneous, patch and RAST testing).

Limitations---We require prior approval for diagnostic services.

GENERAL HOSPITAL SERVICES

Benefits---General hospital services and supplies related to covered medical and surgical services include:

- inpatient room, board and general nursing services for any type of room appropriate for your care;
- outpatient surgery;
- ancillary supplies and services; and
- emergency care.

Benefits for mental health services in a general hospital are applied toward your mental health benefit maximums.

Ancillary supplies and services include, but are not limited to:

- use of operating, delivery and treatment rooms;
- prescribed drugs;
- anesthesia, anesthesia supplies and services provided by an employee of the hospital;
- medical/surgical supplies;
- diagnostic services;
- therapy services;
- laboratory services; and
- intravenous medications, (e.g., steroids, antibiotics and hemophilia agents).

Requirements---We only provide benefits for:

Inpatient facility charges if you obtain **prior approval.**

Emergency care if:

- treatment of injuries resulting from an accident requires emergency accident care or a medical condition requires emergency medical care; and
- emergency care commences within 72 hours of the emergency.

Exclusions---We provide no benefits for:

Additional inpatient days that we determine are not medically necessary.

Facility charges when we determine that the medical/surgical services could have been performed appropriately on an outpatient basis.

Private rooms unless your attending physician and we determine it is medically necessary.

HOME CARE

Benefits---Skilled nursing services (including private duty nursing services) of a registered or licensed practical nurse to:

- perform necessary procedures;
- train your family or other care givers in your home to perform necessary procedures; and
- perform physical, occupational and speech therapy.

We provide benefits for home health aide services (for personal care only) when you are receiving skilled nursing or therapy services up to 40 visits per year. Each visit by a member of a home health care agency, other than a home health aide, shall be considered one home health care visit, and four hours of home health aide service shall be considered one home health care visit.

Requirements---We only provide benefits if:

- you obtain **prior approval**; and
- you are under the care of a physician who:
  a. approves a plan of treatment for a reasonable time;
  b. includes the treatment plan in your medical record; and
  c. certifies that the services are for acute care (not for chronic care).

The patient, or a legally responsible individual, must consent in writing to the home health care treatment plan. The treatment plan must be approved by us and certified by your physician every 60 days.

Exclusions---We provide no benefits for dietitian services, homemaker services, maintenance therapy, custodial care or food or home delivered meals.

HOSPICE CARE

Definitions---

Hospice is 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 Committee of Accreditation of Health Care Organizations.

Benefits---

Skilled nursing visits---up to 2 visits per day.

Home health aide---up to 100 hours per month for personal care services only.

Continuous care---besides respite care, you may receive up to 5 days or 120 hours for the patient's continuous care in your home.

Social service visits---up to 6 visits before the patient's death and up to 2 bereavement visits following the patient's death. Social service visits may include:

- counseling and emotional support;
- assessment of social and emotional factors related to the patient's condition;
- assistance in resolving problems;
- assessment of financial resources; and
- use of available community resources.

Respite care---up to 72 hours each month. Respite care relieves your family or care givers by providing temporary relief from the duties of caring for your terminal illness. Respite care will be provided in a general hospital or in your home, whichever is most appropriate.

Durable medical equipment.

Prescription drugs and supplies.

Requirements---We only provide benefits if:

- a physician certifies that your terminal illness has a prognosis of 6 month life expectancy or less;
- you and your physician consent to the hospice care plan; and
- a primary care giver (family member or friend) will be in the home.

MATERNITY RELATED SERVICES

Maternity---

Benefits---Facility, medical and surgical services for pre-natal care, normal and complicated pregnancies.

Requirements---You must obtain **admission review** after your inpatient admission.

If this contract terminates during your pregnancy, maternity benefits will be provided according to the contract in effect at the time of delivery if your pregnancy began while you were covered under this contract.

Exclusions---We provide no benefits for services related to pregnancy or childbirth if:

- we replace your previous insurance carrier; and
- your previous insurance carrier has extended liability.

Newborn Care---

Benefits--Coverage shall include care for sickness, injury, necessary care and treatment of medically diagnosed congenital defect or birth abnormality, or any combination of these. Routine inpatient nursery care and examinations of your newborn is also covered.

Remember, we only provide benefits under this contract for newborns up to 31 days after birth unless notification of birth is given to us within 31 days after birth.

MEDICAL EQUIPMENT/SUPPLIES

Durable Medical Equipment

Benefits---The rental or purchase of durable medical equipment (DME).

Requirements---We only provide benefits for DME equipment costing over $500 if you obtain **prior approval**.

If we choose to purchase the durable medical equipment:

- we reserve the right to reimburse you the coinsurance and deductible amounts paid for the equipment; and
- the equipment becomes our property if we reimburse you.

Medical Surgical Supplies

Benefits---Medical surgical supplies purchased by you.

Orthotics

Benefits---Rigid or semi-rigid support devices which restrict or eliminate motion of a weak or diseased body part.

Exclusions---We provide no benefits for:

- corrective shoes which are not attached to a brace; or
- "shoe insert orthotics."

Prosthetics

Benefits---The purchase, fitting, necessary adjustments, repairs and replacements of prosthetic devices and supplies that replace:

- all or part of an absent body organ (including contiguous tissue);
- the lens of an eye. (Only one set of eyeglasses or contact lenses will be provided for the original prescription, and one set for each new prescription.); or
- all or part of the function of a permanently inoperative, absent or malfunctioning body part.

Exclusions---We provide no benefits for:

- dental appliances (except as provided under Dental Services); and
- eyeglasses or contact lenses, except when necessary to replace the lens of the eye.

MEDICAL CARE SERVICES

Benefits---

Inpatient medical care visits by a professional provider.

Outpatient home, office and other medical care visits by a professional provider include the examination, diagnosis and treatment of an injury or illness.

Outpatient hospital emergency medical or accident care.

Requirements---

Audiologist---We provide benefits for laboratory hearing tests only if your physician refers you to an audiologist when (s)he finds or reasonably suspects a disease condition or injury.

Emergency medical or accident care---We provide benefits only if care commences within 72 hours after the emergency.

Limitations---

Office visits---We limit benefits for medical care visits to one visit per day.

Exclusions---We provide no benefits for:

Inpatient or outpatient visits for conditions under this section for mental illness, surgery or maternity. These conditions are covered in other sections in this contract.

Hearing care such as hearing aids or examinations for the prescription or fitting of hearing aids.

Eye care examinations for prescribing, fitting or determining your need for eyeglasses or contact lenses. Also, we provide no benefits for:

- the correction of near- or far-sighted conditions by means of corneal microsurgery; and
- eye exercises.

MENTAL HEALTH SERVICES

Definitions---

Mental health services diagnose or treat nervous or mental conditions listed in the Mental Disorders Section in the current International Classification of Diseases Manual (ICD), except:

- conditions related to substance abuse; (refer to Substance Abuse section); and
- conditions of, including, but not limited to: hyperkinetic disorders, developmental delays, mental retardation, and psychological factors associated with diseases classified elsewhere in the ICD.

Benefits---Mental health services furnished and billed by a:

- community mental health facility;
- general or psychiatric hospital;
- physician; or
- mental health professional who is a professional provider as defined.

Inpatient and outpatient professional provider services for the treatment of mental illness include:

- individual and group psychotherapy;
- family counseling to help in diagnosing and treating the patient;
- psychological testing; and
- electroshock treatment or convulsive drug therapy. This benefit includes anesthesia when it is given for this treatment.

Limitations:

Professional Services---We limit benefits to one visit per day.

Maximum Benefits---Benefits for mental health services are limited for each calendar year as shown on your outline of coverage.

Exclusions---We provide no benefits for any mental health services:

- beyond the initial evaluation to diagnose mental deficiency or retardation;
- for mental disorders or illness that, according to generally accepted professional standards, will not improve with treatment;
- for non-health or non-medical reasons; or
- that we determine do not produce evidence of continued improvement or maximum rehabilitative potential within a reasonable and medically predictable period of time.

PHYSICAL REHABILITATION FACILITY SERVICES

Benefits---Inpatient treatment for an acute medical condition.

Requirements---We only provide benefits if:

- you obtain **prior approval**; and
- your attending physician refers you for treatment and obtains recertification from us every 30 days.

Exclusions---We provide no benefits for cognitive retraining and educational programs.

PRESCRIPTION DRUGS

Benefits---Prescription drugs and insulin purchased by you that:

- require a physician's prescription by federal law of the United States;
- are FDA-approved; and
- we approve for the specific medical condition.

PREVENTIVE CARE SERVICES

Benefits---Outpatient office visits by a physician or nurse practitioner include, but are not limited to:

- well child care;
- eye exams;
- routine physical examinations;
- immunizations and injections;
- mammograms; and
- pre-natal care.

Limitations---

Office visits---We limit benefits for medical care visits to one visit per day.

Exclusions---We provide no benefits for:

Hearing care such as hearing aids or examinations for the prescription or fitting of hearing aids.

Eye care examinations for prescribing, fitting or determining your need for eyeglasses or contact lenses. Also, we provide no benefits for:

- the correction of near- or far-sighted conditions by means of corneal microsurgery; and
- eye exercises.

SKILLED NURSING FACILITY SERVICES

Benefits---Inpatient services include:

- room, board (including special diets) and general nursing care;
- medication and drugs; and
- nonsurgical medical services as included in the rates of a skilled nursing facility.

Requirements---We only provide benefits if you obtain **prior approval** and your condition requires acute care.

Limitations---We only provide benefits for as long as it is medically necessary for the proper treatment of the medical condition.

SUBSTANCE ABUSE REHABILITATION SERVICES

Benefits---

Detoxification---up to 5 days per occurrence.

Outpatient rehabilitation (including your family where necessary)---up to 90 hours per occurrence and up to a total of 180 hours per lifetime.

Inpatient rehabilitation---up to 28 days or day equivalents per occurrence with up to 56 days or day equivalents per person per lifetime.

A "day equivalent" is 2 partial days. A partial day means services at a substance abuse treatment facility for more than 2 but less than 24 hours.

Requirements---We only provide benefits:

- if you obtain **prior approval** for **inpatient rehabilitation**;
- for **inpatient detoxification** if your physician certifies that non-hospital detoxification is inappropriate; and
- for **inpatient rehabilitation** if your substance abuse counselor certifies that inpatient treatment is appropriate. The certifying substance abuse counselor cannot be an employee of the facility.

SURGICAL SERVICES

Benefits---

Surgery including operating surgeons, assistant surgeons, team surgeons and co-surgeons.

Special surgery including oral surgery (see Dental Services), reconstructive surgery and sterilization surgery (regardless of the medical necessity).

Anesthetists.

Requirements---We only provide benefits for **reconstructive surgery** if we determine that an overriding medical condition exists and you obtain **prior approval**.

Exclusions---

Pre- and post-operative care---We consider most pre- and post-operative visits part of the surgical benefit. Therefore, we do not provide additional benefits for these services.

Reverse sterilization---We provide no benefits for surgical procedures to reverse sterilization.

THERAPY SERVICES

Benefits---Therapy services for the treatment of an illness or injury include, but are not limited to:

- chemotherapy;
- dialysis treatment;
- infusion therapy;
- inhalation therapy;
- physical therapy;
- radiation therapy;
- occupational therapy. Examples of conditions where benefits may be considered include, but are not limited to:
  a. a cerebral vascular accident;
  b. an amputation (upper extremities);
  c. a spinal cord injury;
  d. burns of upper extremities; or
  e. surgery or injury to the hand or wrist; and
- speech therapy. Examples of conditions where benefits may be considered include, but are not limited to:
  a. removal of the larynx and pharynx;
  b. surgery to correct congenital abnormality; or
  c. a cerebral vascular accident.

Requirements---We only provide benefits if:

Prior Approval is obtained.

Therapy services:

a. produce measurable improvement within a reasonable and medically predictable period of time;
b. show measurable restorative potential and progress;
c. are prescribed by the attending physician.
d. are provided by or billed by a facility or professional provider; and
e. are prescribed by your attending physician.

Occupational therapy begins within 60 days after the date of initial care for the illness or injury.

Speech therapy begins within 60 days after the date of initial care for the illness or injury.

Limitations---

Maximum benefit---We limit your combined total of all of your occupational, physical and speech therapy sessions to a benefit of 40 sessions per calendar year.

Physical therapy---We limit benefits to 6 months after initiation of physical therapy.

Occupational therapy---We limit benefits to 6 months after the date of initial care.

Speech therapy---We limit benefits to 6 months after the date of initial care.

Exclusions---We provide no benefits for:

Speech therapy for speech loss or impairment due to:

a. a functional nervous/psychiatric disorder;
b. mental retardation;
c. nonphysical conditions such as learning disabilities, stuttering, alcoholism; or
d. developmental delays, including, but not limited to lack of normal physiological development; infantile cerebral palsy; multiple sclerosis; hyperkinetic syndrome of childhood; myoneural disorders; and hearing loss or disorder.

Pain management programs, except for physician prescribed TENS units.

TRANSPLANT SERVICES

Benefits---

Organ and bone marrow transplants include but are not limited to:

- heart;
- heart/lung;
- lung;
- liver;
- pancreas;
- allogeneic bone marrow;
- autologous bone marrow;
- cornea;
- kidney; or
- tissue.

Related transplant expenses---We provide benefits for services directly related to the search, surgical removal, storage and transportation costs for the organ, bone marrow or tissue.

Donor expenses---We provide benefits for a live donors medical expenses:

- if their human organ, bone marrow or tissue transplant is donated to a human transplant recipient;
- when only you (as the recipient) are covered by us; and
- up to the transplant lifetime maximum benefit. Benefits available to you will be paid first. Remember, benefits provided to the donor will be charged against your coverage.

When we cover both the recipient and the donor, each is entitled to the benefits of his/her contract. We provide no other benefits to a donor covered under this contract, except as described above.

Requirements---We only provide benefits if **prior approval** is obtained at least 72 hours before inpatient admission. We reserve the right to review all requests for prior approval based on:

- the patient's medical condition;
- the physicians' qualifications performing the transplant procedure; and
- the facilities' qualifications hosting the transplant procedure.

We use the above information to determine whether it is consistent with our criteria.

Limitations

Time period---We provide benefits for recipient expenses that are directly related to the transplant procedures for the period of time from 5 days before the procedure to 52 weeks after the procedure. Any benefits provided outside of this period of time are subject to the terms and conditions in the other sections of this contract.

Related transplant expenses---We limit benefits to $10,000 per transplant.

Lifetime maximum benefit---We limit benefits to a combined lifetime total of $1,000,000 for all transplants.

Exclusions---We provide no benefits for:

- services or supplies related to transplant procedures (artificial or human) considered investigational or experimental, as defined ;
- the purchase price of any organ or tissue that is sold rather than donated; and
- any organ transplant for which, and to the extent that, the patient or donor receives research or grant funding directly or through a provider.

ARTICLE IV
EXCLUSIONS

GENERAL

This contract does not provide benefits for services or supplies **that**:

- a prior health plan is obligated to cover as extended benefits.
- you would have no legal obligation to pay in the absence of this contract or any similar coverage.
- are not specifically listed as covered services.
- are charged:
  a. for failure to keep a scheduled visit;
  b. for completion of a claim form; and
  c. in excess of the limitations set forth in this contract.
- we determine are not medically necessary.
- we determine are investigative in nature.

PROVIDERS

This contract does not provide benefits **for services or supplies** provided by:

- a professional provider who:
  a. is enrolled in an education or training program when such services are related to the education or training program; or
  b. is a member of the immediate family (services only).
- a school infirmary.
- a Veterans Administration facility for a service-connected disability.
- anyone without charge or paid for directly or indirectly by a local, state or federal government agency (except Medicaid or a Veterans Administration facility in connection with a non-service-connected disability).

SERVICES AND SUPPLIES

This contract does not provide benefits **for**:

- acupuncture.
- automatic ambulatory blood pressure monitoring.
- biofeedback and other forms of self-care or self-help training.
- chiropractic care.
- conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation or for inpatient confinement for environmental change.
- contraceptives and contraceptive devices.
- cosmetic surgery.
- custodial care, domiciliary care or rest cures.
- drugs and pharmaceuticals that by federal law do not require a prescription in the United States.
- educational evaluation or therapy.
- illnesses or injuries sustained:
  a. in the course of employment. (This exclusion does not apply to any persons for whom Workers' Compensation insurance is optional under Vermont Title 21, Section 601, and who choose not to obtain such insurance.); or
  b. on or after the effective date of enrollment:
    i. as a result of an act of war within the United States, its territories or possessions;
    ii. while in active military service; or
    iii. during combat, unless otherwise required by law.
- institutional or custodial care for the physically or mentally handicapped.
- nutritional counseling.
- pain management programs (Except for physician prescribed TENS units).
- palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), callouses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet.
- personal hygiene and convenience items including, but not limited to: air conditioners, humidifiers, physical fitness equipment, stair glides, elevators, lifts, "barrier free" or other home modifications, whether or not prescribed by a provider.

- support therapies, including but not limited to: marriage counseling, pastoral counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy smoking cessation, and stress management.
- routine dental care.
- telephone consultations
- telephone, television, guest trays, beauty, barber and other personal service items.
- travel, whether or not prescribed by a physician.
- therapy services as a part of diabetic, developmental, pulmonary or other form of rehabilitation, except upon **prior approval** by us.
- treatment of obesity. However, we will provide benefits for the surgical treatment of morbid obesity if:
  a. your weight is at least twice the ideal weight specified for your frame, age, height and sex; and
  b. you have other medical conditions present which could be significantly and adversely affected by this degree of obesity.
- treatment leading to or in connection with transsexual surgery, artificial insemination, in vitro fertilization and embryo transplantation.
- whole blood.