MEDI-COMP III
MEDICARE
COMPLEMENTARY
CONTRACT

Offered by
VERMONT HEALTH SERVICE CORPORATION

THIS CONTRACT PROVIDES:

1. Benefits equal to the deductible amounts under Parts A and B of Medicare (not including that deductible relating to blood)
2. Benefits equal to the coinsurance under Parts A and B of Medicare

AGREEMENT: By paying for and accepting Medi-Comp III, the subscriber is entitled to benefits under the terms and conditions explained in this document. Benefit coverage will begin with the effective date stated on the identification card and will continue until the contract is terminated.

RENEWAL: The subscriber may renew this contract for further consecutive periods by paying the premiums as specified in Article VII herein.

EXAMINATION RIGHT: Any time within the first 30 days this contract is in the subscriber's possession, it may be cancelled by returning it to Blue Cross and Blue Shield and any premiums paid for this contract will be fully refunded.

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ARTICLE I
GENERAL DEFINITIONS

BENEFIT PERIOD – a calendar year.

CONTRACT – the entire agreement between the subscriber and the Plan. This written document, the application card, any supplements and endorsements issued by the Plan and the identification card make up the entire agreement.

COVERED MEDICAL EXPENSE – expense incurred by the subscriber after the effective date of this contract for health services and supplies that are recognized as legitimate expenses under the provisions of Medicare but for which maximum Medicare benefits have been paid.

CUSTODIAL CARE – care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in performing activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Multiple non-skilled nursing services/skilled rehabilitation services in the aggregate do not constitute covered services. Custodial Care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets and supervision over administration of medications not requiring skilled nursing services/skilled rehabilitation services provided by trained and licensed medical personnel, and may include intermittent skilled nursing services. Custodial Care is not a covered service.

INCURRED EXPENSE – an expense created on the date a service is actually performed or rendered.

MEDICALLY NECESSARY – services or supplies provided by a Provider that the PLAN OR ITS DESIGNATED AGENT DETERMINES are:

a. appropriate for the symptoms and diagnosis or treatment of the subscriber's condition, illness, disease or injury;

b. provided for the diagnosis or direct care and treatment of the subscriber's condition, illness, disease or injury;

c. in accordance with standards of good medical practice;

d. not primarily for the convenience of the subscriber or the Provider; and

e. the most appropriate supply or level of service that can safely be provided to the subscriber.

MEDICARE – the two programs of health insurance established under Parts A and B of Title XVIII of the Social Security Act, Public Law 89-97, as amended.

NON-PARTICIPATING HOSPITAL – any institution that does not meet the definition of “participating hospital.”

PARTICIPATING HOSPITAL – an institution which provides continual diagnostic and therapeutic care under the supervision of physicians. The institution must hold a contract with the Secretary of Health and Human Services or a Blue Cross Plan for such purpose. Institutions not considered hospitals are: a rest, nursing, aged, drug abuse or mental home and a psychiatric facility.

PHYSICIAN – any licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), or Podiatrist, acting within the scope of that license.

PLAN – Vermont Health Service Corporation doing business as Blue Cross and Blue Shield of Vermont.

PROVIDER – physicians, hospitals, skilled nursing facilities, home health agencies and other providers recognized by Medicare.

ARTICLE II
ELIGIBILITY AND COMMENCEMENT OF COVERAGE

A. This Medi-Comp III contract is specifically intended for only those individuals enrolled in Parts A and B of Medicare.

B. Coverage under this contract becomes effective on the date stated on the subscriber's identification card for approved Medicare services occurring on or after the effective date.

ARTICLE III
COMPLEMENTARY BENEFITS

A. To complement Part A of Medicare per benefit period, benefits will be provided equal to:

1. the inpatient hospital deductible amount (not including that deductible relating to blood); and

2. the per day coinsurance, from the 1st day through the 8th day, for skilled nursing facility care.

B. To complement Part B of Medicare per benefit period, benefits will be provided equal to:

1. the deductible amount (not including that deductible relating to blood); and

2. the coinsurance for physician and other related services as covered by the Medicare Program.

ARTICLE IV
CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

A. For the purpose of the approval or denial of benefits, the Plan reserves the right to

1. obtain all documentation related to any services received by a subscriber;

2. require written evidence of medical necessity, including a statement of need for continued care by an attending physician;

3. subject all benefit payment to the Utilization Review-Medical Necessity Guidelines of both Medicare and the Plan;

4. require review by a medical board assigned by the Plan.

B. When requesting health care services, the subscriber is responsible for identifying himself as a Blue Cross and Blue Shield subscriber.

ARTICLE V
LIMITATIONS AND EXCLUSIONS

A. Limitations

1. Benefits are only available to the subscriber for ap-
B. This contract shall not be in force until the initial premium.

C. Premiums

A. The initial premium shall be paid on or before the effective
date of this Medi-Comp III coverage, and
b. when recommended by, and under the care of, a
physician who is subject to the regulations
governing admissions to hospitals and skilled
nursing facilities.
2. Benefits will not exceed the Medicare-approved
charges.

B. Exclusions

No benefits will be provided for:
1. any services not covered by Medicare.
2. any services received in hospitals not participating
with Medicare.
3. dental care unless it involves setting fractures or sur-
gery of the jaw and related structures as approved
under the Medicare program.
4. cosmetic surgery and related supplies unless
necessary
a. for the prompt repair of accidental injury, or
b. to improve the functioning of a malformed part of
the body;
5. services and supplies not directly related to or neces-
sary for the treatment of an injury or illness;
6. services or supplies available without cost to the sub-
scriber under
a. the laws of any sovereign state including Work-
men's Compensation,
b. the maritime doctrine of maintenance, wages and
cure (medical aid while aboard ship at sea),
c. the Veterans' Administration,
d. the Medicare program;
7. disease or injury sustained as a result of war;
8. eyeglasses, contact lenses, hearing aids, and related
examinations for their prescription or fitting;
9. routine foot care including services and supplies for
the removal of corns, warts, calluses, or the trimming
of toenails;
10. travel, whether or not recommended by a physician;
II. convalescent care, custodial care or rest cures;
12. prescription drugs and medicines when patient not
confined in a hospital or skilled
nursing facility;
13. charges disallowed by Medicare for private rooms not
medically necessary.

ARTICLE VI
PREMIUMS

A. The initial premium shall be paid on or before the effective
date of this Medi-Comp III contract.
B. This contract shall not be in force until the initial premium
has been received by Blue Cross and Blue Shield.
C. Premiums for further consecutive periods of coverage
shall be payable in advance or within the grace period
provided in Article VIII.
D. The Plan may change the premiums for this contract:
1. when a written notice is given,
2. when the action taken applies to all like contracts, and
3. when approved by the Vermont Department of Bank-
ing and Insurance.
E. In order to allow continued coverage of the full deductibles
and coinsurance amounts as specified in Article III, the
premiums charged for this contract may be adjusted as
of January 1 of each year, as the deductibles and coinsur-
ance amounts established under Medicare change.

ARTICLE VII
GENERAL PROVISIONS

A. The rights of a subscriber under this contract are personal
to the subscriber and are not assignable.
B. No statement of the subscriber in his application shall void
the contract or be used in any legal proceedings unless the
application or an exact copy is included in, or attached to,
the subscriber contract.
C. Claims will not be accepted after three years from the
original date of service.
D. The Plan will pay the provider directly, whenever pos-
sible, for services supplied to a subscriber. However, the
Plan may, at its discretion, reimburse the subscriber
directly.
E. The Plan is not required to provide any equipment or sup-
plies to a provider for any reason.

ARTICLE VIII
TERMINATION, RENEWAL AND REINSTATEMENT

A. Blue Cross and Blue Shield may terminate this contract for
nonpayment, fraud, failure of the subscriber to maintain
Parts A and B of Medicare, residency outside of the United
States for more than 6 months, or when the Plan ter-
minates all like contracts.
B. The subscriber may terminate this contract at the end of
the period for which premiums have been paid.
C. A grace period of 12 days will be granted for the payment
of each premium. If a premium payment is not received
by the Plan within the grace period, this contract will auto-
matically terminate at the end of the preceding payment
period. No benefits will be provided after the termination
date.
D. The subscriber may renew this contract for further con-
secutive periods by paying the premiums as specified in
Article VI.
E. Once terminated, a subscriber may be reinstated by the
Plan upon such terms and conditions as it may determine.

ARTICLE IX
CHANGES AND OBLIGATION TO NOTIFY

A. No agent has the authority to change this contract or to
waive any of its provisions without approval of an Execu-
tive Officer of the Plan.
B. In the event that the provisions of this contract are changed
or revised, the subscriber will be given a notice 30 days
prior to the effective date of the changes. If the subscriber
continues his premium payment it will be understood that
he has accepted the changes.
C. Any notice given under this contract will be sufficient
when addressed to:
1. The subscriber, at the last address shown on the Plan's
records, or
2. Subscriber Services
Vermont Health Service Corporation
P. O. Box 186
Montpelier, Vermont 05602

ARTICLE X
SUBROGATION

A. To the extent that benefits are paid under this Contract, the
Plan shall be subrogated to any rights of recovery of a
Member from any person or organization except insurers on policies of health insurance issued to and in the name of the Member. This means that:

If a Member receives medical treatment for injuries caused by another person, and the Plan pays for any part of that medical treatment, the Member shall pay the Plan all amounts he or she recovers by suit, settlement, or otherwise from any third party or his insurer, to the extent of the benefits paid under this Contract.

B. The Member shall take such action, furnish such information and assistance, and execute such papers as the Plan may require to facilitate enforcement of its rights, and shall take no action prejudicing the rights and interests of the Plan under this Contract.

C. If the Member refuses to pay to the Plan or to provide the necessary information, the Plan may take legal action against the Member to recover amounts paid.

D. These provisions shall not apply where subrogation is specifically prohibited by law.

E. The Plan reserves the right to compromise the amount of its claim if, in its opinion, it is appropriate to do so.

ARTICLE XI
RELEASE OF INFORMATION
By accepting this coverage, each Member gives the Plan or its designated agent the right to obtain from the Member or from any other source all records, copies of records, testimony, or other information needed by the Plan or its designated agent to adjudicate and/or process that Member's claims.

The Plan may furnish this information to other entities providing similar benefits at their request. The Plan or its designated agent shall also have the right to obtain such information for the purpose of performing utilization review studies and analyses for benefit program analysis.

Approval by the Plan or its designated agent of any benefits is contingent upon the furnishing of such information.