MEDI-COMP I
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
3. Extended Benefits beyond Medicare

AGREEMENT: By paying for and accepting Medi-Comp I, 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 or 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 or 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.

SKILLED NURSING FACILITY — an institution or part of an institution that provides skilled nursing care at a level of care less than that required in a hospital. The facility must have a participating agreement with the Secretary of Health and Human Services.

SUBSCRIBER — an individual who is entitled to Medicare, who has applied for and been accepted for Medi-Comp I and whose name appears on the identification card issued by the Plan.

UNITED STATES — all the states, the District of Columbia, the Virgin Islands, Puerto Rico, American Samoa and Guam.

USUAL AND CUSTOMARY CHARGES — the charges generally made for similar services and those prevailing in the locality for similar services as determined by Medicare regulations.

ARTICLE II
ELIGIBILITY AND COMMENCEMENT OF COVERAGE

A. This Medi-Comp I 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
EXTENDED BENEFITS

A. Extended Benefits reimburse the subscriber for 80% of the Medically Necessary covered medical expense (see definition in Article I) exceeding the deductible amount, for the following services:
   1. covered medical expense in a hospital within the United States; and
   2. covered medical expense in a hospital outside the United States.

B. Extended Benefits pay 100% of any usual and customary nonreplacement fee for the first three pints of whole blood or units of packed red blood cells.

C. Deductible
   1. The subscriber is responsible for paying the first $100 of incurred covered medical expense each year under this Extended Benefits coverage.
   2. Any covered medical expenses incurred during October, November and December of any year which are applied against that year’s deductible amount may also
be carried over and applied against the deductible amount for the following calendar year, and
3. None of the benefits paid by this Medi-Comp I coverage will be a credit toward this deductible amount.

D. If this contract is terminated, Extended Benefits will continue to be provided up to 90 days after the termination date for sickness or injury which began prior to the termination date.

E. Limitations and Exclusions
1. The lifetime maximum a subscriber can receive in Extended Benefits is $10,000. After receiving benefits of $1,000 or more, the subscriber may apply for reinstatement of the $10,000 maximum by furnishing proof of insurability satisfactory to the Plan.
2. No Extended Benefits are provided for services and supplies in:
   a. skilled nursing facilities, and
   b. non-participating hospitals in the United States.
3. Extended Benefits are subject to the limitations and exclusions of Article VI except where provisions are made in this Article IV.

ARTICLE V
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 payments 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 VI
LIMITATIONS AND EXCLUSIONS
A. Limitations
1. Benefits are only available to the subscriber for approved Medicare services:
   a. provided on or after the effective date of this Medi-Comp I 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 (except as provided under Extended Benefits Article IV);
3. dental care unless it involves setting fractures or surgery 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 necessary for the treatment of an injury or illness;
6. services or supplies available without cost to the subscriber under
   a. the laws of any sovereign state including Workmen'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;
11. 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 VII
PREMIUMS
A. The initial premium shall be paid on or before the effective date of this Medi-Comp I 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 IX.
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 Banking 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 coinsurance amounts established under Medicare change.

ARTICLE VIII
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. If the subscriber is not enrolled through a group, any payment for a service covered by Medi-Comp I may not be reduced or prorated because the subscriber has other insurance.
E. 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.

F. The Plan is not required to provide any equipment or supplies to a provider for any reason.

ARTICLE IX
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 terminates 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 automatically terminate at the end of the preceding payment period. No benefits will be provided after the termination date except as provided for in Article IVD.

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

E. Once terminated, a subscriber may be reinstated by the Plan upon such terms and conditions as it may determine.

ARTICLE X
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 Executive 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 XI
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 XII
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.