

VERMONT MEDIGAP BLUESM
**OUTLINE OF
COVERAGE**

for Plans A, D, G, and N
and Plans C and F for applicants first
eligible for Medicare before 2020

If you have questions about
our Plans, call our customer
service department toll free
at (800) 625-6406.



An Independent Licensee of the Blue Cross and Blue Shield Association.

Premium Information

Use this Outline to compare benefits and rates among certificates. If you have already enrolled, use this Outline to understand your coverage.

This Outline shows benefits and rates of coverage sold for effective dates on or after January 1, 2024.

Direct Enroll Monthly Rate

Plan A Individual:	\$175.64
Plan D Individual:	\$190.21
Plan G Individual:	\$190.65
Plan N Individual:	\$177.17
Plan C Individual**:	\$222.15
Plan F Individual**:	\$222.62

**** Note:** Plan C and F are only available to applicants who were first eligible for Medicare before 2020.

Direct Enroll Monthly Rate for Vermonters with Disabilities

Plan A for Vermonters with Disabilities:	\$420.94
Plan D for Vermonters with Disabilities:	\$462.57
Plan G for Vermonters with Disabilities:	\$463.84
Plan N for Vermonters with Disabilities:	\$425.35
Plan C for Vermonters with Disabilities**:	\$515.15
Plan F for Vermonters with Disabilities**:	\$516.52

The premiums included in this outline of coverage are the same whether or not you use the services of a broker or agent.

Disclosures

Premium Information

We, The Vermont Health Plan, can only raise your premium if we raise the premium for all policies like yours in this State.

Read Your Certificate Very Carefully

This is only an Outline, describing your certificate's most important features. The certificate is your insurance contract. You must read the certificate itself to understand all the rights and duties of both you and The Vermont Health Plan.

Right to Return Certificate

If you find that you are not satisfied with your certificate, you may return it to The Vermont Health Plan, P.O. Box 186, Montpelier, VT 05601-0186 or call (800) 255-4550. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all of your payments.

Certificate Replacement

If you are replacing other health insurance policy, do **not** cancel it until you have actually received your new certificate and are sure you want to keep it.

Notice

- This certificate may not fully cover all of your medical costs.
- This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult Medicare and You for more details.
- The Vermont Health Plan is not connected with Medicare.

Complete Answers Are Very Important

When you fill out the application for the new coverage, be sure to answer truthfully and completely all questions about your medical and health history.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Outline of Coverage

Benefit Chart of Medicare Supplement Plans Sold

(for effective dates on or after January 1, 2024)

This chart shows the benefits included in each of the standard Medicare supplement plans. The Vermont Health Plan offers Plans A, D, G and N as well as Plans C and F for applicants first eligible for Medicare before 2020.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G ¹	K	L	M	N	C	F ¹
Medicare Part A co-insurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B co-insurance or co-payment	✓	✓	✓	✓	50%	75%	✓	✓ co-pays apply ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care co-insurance or co-payment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility co-insurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			80%	80%			80%	80%	80%	80%
Out-of-pocket limit in 2024 ²					\$7,060 ²	\$3,530 ²				

¹Plans F and G also have a high deductible option which require first paying a plan deductible of \$2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

²Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³Plan N pays 100% of the Part B co-insurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies.			
– First 60 days	All but \$1,632	\$0	\$1,632 (Part A deductible)
– 61st through 90th day	All but \$408 a day	\$408 a day	\$0
– 91st day and after, while using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
– Once lifetime reserve days are used: additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
– First 20 days	All approved amounts	\$0	\$0
– 21st through 100th day	All but \$204 a day	\$0	Up to \$204 a day
– 101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES			
in or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (above Medicare-approved amounts)			
	\$0	\$0	All costs
BLOOD			
First three pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0

MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
DURABLE MEDICAL EQUIPMENT:			
– First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

* Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
- First 60 days	All but \$1,632	\$1,632 (Part A deductible)	\$0
- 61st through 90th day	All but \$408 a day	\$408 a day	\$0
- 91st day and after, while using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
- Once lifetime reserve days are used: additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
- First 20 days	All approved amounts	\$0	\$0
- 21st through 100th day	All but \$204 a day	Up to \$204 a day	\$0
- 101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES			
in or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD			
First three pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0

MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
DURABLE MEDICAL EQUIPMENT:			
– First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL (Not Covered By Medicare)			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

* Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MISCELLANEOUS SERVICES AND SUPPLIES			
– First 60 days	All but \$1,632	\$1,632 (Part A deductible)	\$0
– 61st through 90th day	All but \$408 a day	\$408 a day	\$0
– 91st day and after, while using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
– Once lifetime reserve days are used: additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
– First 20 days	All approved amounts	\$0	\$0
– 21st through 100th day	All but \$204 a day	Up to \$204 a day	\$0
– 101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES			
in or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES			
(above Medicare-approved amounts)**	\$0	100%	\$0
BLOOD			
First three pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0

MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			\$240
– First \$240 of Medicare-approved amounts*	\$0	\$0	(Unless Part B deductible has been met)
– Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL (Not Covered By Medicare)			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

* Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** Plan G covers Part B excess charges, or the difference when the amount a doctor or other health care provider is legally permitted to charge is higher than the Medicare-approved amount. Vermont law generally prohibits a physician from charging more than the Medicare-approved amount. However, there are exceptions and this prohibition may not apply if you receive services out of state.

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
– First 60 days	All but \$1,632	\$1,632 (Part A deductible)	\$0
– 61st through 90th day	All but \$408 a day	\$408 a day	\$0
– 91st day and after, while using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
– Once lifetime reserve days are used: additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
– First 20 days	All approved amounts	\$0	\$0
– 21st through 100th day	All but \$204 a day	Up to \$204 a day	\$0
– 101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES			
in or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	**
PART B EXCESS CHARGES (above Medicare-approved amounts)			
	\$0	\$0	All costs
BLOOD			
First three pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0

MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
DURABLE MEDICAL EQUIPMENT:			
– First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL (Not Covered By Medicare)			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

* Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** The co-payment of up to \$50 is waived if you are admitted to any hospital and the emergency visit is covered by Medicare Part A.

PLAN C

for applicants first eligible for Medicare before 2020

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
– First 60 days	All but \$1,632	\$1,632 (Part A deductible)	\$0
– 61st through 90th day	All but \$408 a day	\$408 a day	\$0
– 91st day and after, while using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
– Once lifetime reserve days are used: additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
– First 20 days	All approved amounts	\$0	\$0
– 21st through 100th day	All but \$204 a day	Up to \$204 a day	\$0
– 101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

for applicants first eligible for Medicare before 2020

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES			
in or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$240 of Medicare-approved amounts*	\$0	\$240 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (above Medicare-approved amounts)			
	\$0	\$0	All costs
BLOOD			
First three pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$240 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0

MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
– First \$240 of Medicare-approved amounts*	\$0	\$240 (Part B deductible)	\$0
– Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL (Not Covered By Medicare)			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

* Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN F

for applicants first eligible for Medicare before 2020

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
– First 60 days	All but \$1,632	\$1,632 (Part A deductible)	\$0
– 61st through 90th day	All but \$408 a day	\$408 a day	\$0
– 91st day and after, while using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
– Once lifetime reserve days are used: additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
– First 20 days	All approved amounts	\$0	\$0
– 21st through 100th day	All but \$204 a day	Up to \$204 a day	\$0
– 101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

for applicants first eligible for Medicare before 2020

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES			
in or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$240 of Medicare-approved amounts*	\$0	\$240 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES			
(above Medicare-approved amounts)**			
	\$0	All costs	\$0
BLOOD			
First three pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$240 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0

MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
– First \$240 of Medicare-approved amounts*	\$0	\$240 (Part B deductible)	\$0
– Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL (Not Covered By Medicare)			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

* Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** Plan F covers Part B excess charges, or the difference when the amount a doctor or other health care provider is legally permitted to charge is higher than the Medicare-approved amount. Vermont law generally prohibits a physician from charging more than the Medicare-approved amount. However, there are exceptions and this prohibition may not apply if you receive services out of state.



**The Vermont
Health Plan**

An independent licensee of the Blue Cross and Blue Shield Association.

The Vermont Health Plan

P.O. Box 186

Montpelier, VT 05601-0186