



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

# VERMONT BLUE 65<sup>SM</sup>

## 2026 MEDICARE SUPPLEMENT INSURANCE PLANS

Additional Protection and Peace  
of Mind for Individuals with  
Original Medicare

Scan to explore  
plan options



### INSIDE:

Original Medicare  
Medicare Supplement  
Plans & Premiums  
Drug Coverage  
How to Enroll



[bluecrossvt.org/vtblue65](https://bluecrossvt.org/vtblue65)

@bluecrossvt

# ORIGINAL MEDICARE

## PEACE OF MIND WITH MEDICARE COVERAGE

Original Medicare, known as Medicare Part A and Part B, helps cover many medical expenses, but it doesn't cover everything. You're still responsible for:

- Part A and Part B deductibles
- About 20% of your medical costs after paying your deductible
- Prescription drug costs (not included in Original Medicare)

That's why many people choose additional coverage to help fill the gaps left by their Original Medicare. A local partner can walk you through your options and guide you to the plan that best fits.

## WHAT IS ORIGINAL MEDICARE?

Medicare is the federal health insurance program for those aged 65 and older, under 65 with certain health conditions or disabilities, or with End-Stage Renal Disease (ESRD). There are two different parts for Original Medicare: **Medicare Part A**, known as hospital insurance and **Medicare Part B**, known as medical insurance.

- If you're receiving Social Security retirement income before turning 65, you'll automatically be enrolled in Medicare Part A & Part B.
- For many, Medicare Part A is \$0. If you or your spouse paid Medicare taxes long enough while working, generally at least 10 years (40 quarters), you qualify for premium-free Part A coverage. If you don't qualify for premium-free Part A, you will need to pay a monthly premium, which can be found in the "Medicare Costs" section at **Medicare.gov**.
- If you are eligible for Medicare Part A, with or without a cost, you can also enroll in Medicare Part B. A monthly premium is required for Medicare Part B. Most will pay the standard premium amount, but if your modified gross income is above a certain amount, you may pay more. The Medicare Part B premium can be deducted directly out of your Social Security benefit payment.
- Timing for Medicare Part B enrollment varies based on individual circumstances. However, in most cases, if you don't sign up for Medicare Part B when you're first eligible, you'll pay a late enrollment penalty.

You can enroll in Medicare Part A and Part B by contacting Social Security at **SSA.gov/Medicare** or **(800) 772-1213**, TTY: **(800) 325-0778**. You can also set up an appointment at your local Social Security Office.

## MEDICARE PART A - Hospital Insurance

- Inpatient hospital care
- Care in a skilled nursing facility (SNF)
- Home health services
- Hospice care

## MEDICARE PART B - Medical Insurance

- Physician services
- Hospital outpatient services (medical care or treatment that does not require an overnight stay in a hospital or medical facility)
- Laboratory & diagnostic services
- Durable medical equipment (DME)
- Home health services
- Ambulance
- Some preventive services

# MEDICARE SUPPLEMENT PLAN BASICS

Medicare Supplement insurance plans, also known as Medigap plans, help cover the out-of-pocket costs that Original Medicare does not, such as deductibles, coinsurance, and copayments. While benefits are standardized, these plans offer added financial protection and greater peace of mind. Medicare Supplement plans can be a smart option for Vermonters who value the freedom to see any provider that accepts Medicare, whether locally or throughout the U.S.

Our Vermont Blue 65<sup>SM</sup> plans are for those who are already enrolled in Medicare and looking for a Medicare Supplement plan to provide additional coverage.

## ADDING OUR VERMONT BLUE 65<sup>SM</sup> COVERAGE

We offer the following Medicare Supplement plans through Vermont Blue 65. Each plan has a monthly premium, and you'll need to pay this cost in addition to your Medicare Part B premium to Social Security.

Plan A	Plan C *	Plan D
Plan F *	Plan G	Plan N

\* If you became eligible for Medicare before January 1, 2020, you can enroll in Plan C or Plan F.

### Benefits include:

- Access to any provider or healthcare facility in the U.S. that accepts Medicare
- No referrals to see a specialist or other providers
- Coverage that travels with you across the U.S.
- Flexibility to enroll anytime outside of your Initial Enrollment Period (IEP) or the Medigap Open Enrollment Period.
- Peace of mind knowing you have additional coverage for out-of-pocket costs for your health care needs that are left unpaid by Original Medicare.

## WE'RE HERE TO HELP.

If you have any questions, please reach out to us Monday — Friday, 8 a.m. to 4:30 p.m.

 Phone: **(800) 255-4550 (TTY/TDD: 711), option 4**

 Email: **[consumersupport@bcbsvt.com](mailto:consumersupport@bcbsvt.com)**

 Visit us online: **[bluecrossvt.org/vtblue65](https://bluecrossvt.org/vtblue65)**

## IMPORTANT RESOURCES

### Medicare

Visit: **[Medicare.gov](https://www.medicare.gov)**

Call: (800) MEDICARE | (800) 633-4227

TTY Users: (877) 486-2048

### Social Security Administration (SSA)

To sign up for Medicare, apply for the Extra Help program if you have limited income or resources, or talk about retirement income benefits

Visit: **[SSA.gov](https://www.ssa.gov)**

Call: (800) 772-1213

TTY Users: (800) 325-0778

### Vermont Association of Area Agencies on Aging

Providing advocacy and education for those nearing Medicare age

Visit: **[Vermont4a.org](https://www.vermont4a.org)** to find our local agency

Call: (800) 642-5119

# PLANS & PREMIUMS

## ALL STANDARD MEDICARE SUPPLEMENT PLANS

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan A available. Some plans may not be available in Vermont. **We offer Plans A, C\*, D, F\*, G, and N as highlighted below.**

Monthly Premium	\$290.88		\$424.98	\$399.16		\$425.77	\$399.98				\$369.95
All Medicare Beneficiaries enrolled in Medicare Part A & Part B.	A	B	C	D		F* <sup>1</sup>	G* <sup>1</sup>	K	L	M	N
<div><p>*If you became eligible for Medicare prior to January 1, 2020, you may have additional Medicare Supplement plan options—including Plan C and Plan F.</p><p>Questions? We're here to help! Call: (800) 255-4550 (TTY/TDD: 711), option 4</p><p>Email: <a href="mailto:consumersupport@bcbsvt.com">consumersupport@bcbsvt.com</a></p><p><b>Read your certificate very carefully</b></p><p>You must read the Certificate itself to understand all the rights and duties of both you and your health plan.</p><p>NOTICE: This plan may not fully cover all your medical costs.</p><p>This chart does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the government publication <b>"Medicare &amp; You"</b> for more details.</p></div>	Basic Benefits, including 100% Part A coinsurance Part B coinsurance	Basic Benefits, including 100% Part A coinsurance Part B coinsurance	Basic Benefits, including 100% Part A coinsurance Part B coinsurance	Basic Benefits, including 100% Part A coinsurance Part B coinsurance		Basic Benefits, including 100% Part A coinsurance Part B coinsurance	Basic Benefits, including 100% Part A coinsurance Part B coinsurance	Hospital and preventive care paid at 100%; other basic benefits paid at 50%	Hospital and preventive care paid at 100%; other basic benefits paid at 75%	Basic benefits, including 100% Part A coinsurance Part B coinsurance	\$20 copayment <sup>2</sup> for office visits, \$50 copayment <sup>2</sup> for ER; other basic benefits, including 100% Part A coinsurance Part B coinsurance
			100% Skilled Nursing Facility coinsurance	100% Skilled Nursing Facility coinsurance		100% Skilled Nursing Facility coinsurance	100% Skilled Nursing Facility coinsurance	50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance	100% Skilled Nursing Facility coinsurance	100% Skilled Nursing Facility coinsurance
		100% Part A Deductible	100% Part A Deductible	100% Part A Deductible		100% Part A Deductible	100% Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	100% Part A Deductible
			100% Part B Deductible			100% Part B Deductible					
						100% Part B Excess	100% Part B Excess				
			80% Foreign Travel Emergency	80% Foreign Travel Emergency		80% Foreign Travel Emergency	80% Foreign Travel Emergency			80% Foreign Travel Emergency	80% Foreign Travel Emergency

<sup>\*1</sup>: Plan F and Plan G also have a high-deductible option which requires meeting the plan's deductible of \$2,950 before the plan begins to pay. Once the plan's 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 Plan F and Plan G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

### Right to Return Policy

If you find that you are not satisfied with your plan, you may cancel it. If canceled within the first 30 days, we will treat the contract as if it had never been issued and return all of your payments.

## BASIC BENEFITS

**Hospitalization** - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

**Blood** - First three pints of blood each year.

**Hospice** - Part A coinsurance.

**Medical Expenses** - Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require members to pay a portion of Part B coinsurance or copayments.

<sup>2</sup>: Plan N pays 100% of the Medicare Part B coinsurance after you meet your Medicare Part B deductible. After you pay your full Medicare Part B deductible, you may pay up to a \$20 copayment for each office visit and up to a \$50 copayment for an emergency room visit if it does not result in an inpatient admission.

Out-of-pocket limit \$8,000; paid at 100% after limit reached	Out-of-pocket limit \$4,000; paid at 100% after limit reached
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This material is a solicitation of insurance. Blue Cross® and Blue Shield® of Vermont is an independent licensee of the Blue Cross and Blue Shield Association. Blue Cross and Blue Shield of Vermont is not connected with or endorsed by the U.S. government or the federal Medicare program. All Medicare Supplement plans are insured by Blue Cross and Blue Shield of Vermont. Insured by the Blue Cross and Blue Shield of Vermont Medicare Supplement plan series: Plan A (280.54), Plan C (280.55), Plan D (280.474), Plan F (280.391), Plan G (280.506), Plan N (280.593).

# MEDICARE PART D PRESCRIPTION DRUG COVERAGE

A Medicare Supplement plan does not include prescription drug coverage, but it is available to purchase separately. A Medicare Prescription Drug Plan (Part D) helps cover the cost of prescription drugs — generic and brand-name — and is a perfect complement to a Medicare Supplement plan.

You can choose a Medicare prescription drug plan through a private insurance company approved by Medicare. Part D plans can vary in drug coverage and costs, such as monthly premiums, deductibles, and copayments.

## OUR MEDICARE PART D PLAN OPTIONS

Blue Cross and Blue Shield of Vermont, in a joint venture with three other New England Blue plans, contracts with the Federal government to offer Medicare prescription drug coverage, called Blue MedicareRx<sup>SM</sup>. These plans provide drug coverage to supplement your Original Medicare. To learn more about Blue MedicareRx plans, Medicare Part D, eligibility rules, and enrollment options, visit [RxMedicarePlans.com](https://www.RxMedicarePlans.com). You may also call the Blue MedicareRx team at (888) 496-4178 (TTY: 711), 24 hours a day, 7 days a week.

Blue Cross and Blue Shield of Vermont, in a joint venture with three other New England Blue plans, contracts with the Federal Government to offer Medicare prescription drug coverage, called Blue MedicareRx<sup>SM</sup> (PDP). Blue MedicareRx is a Prescription Drug Plan with a Medicare contract. Blue MedicareRx Value Plus (PDP) and Blue MedicareRx Premier (PDP) are two Medicare Prescription Drug Plans available to service residents of Connecticut, Massachusetts, Rhode Island, and Vermont. Coverage is available to residents of the service area.

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross and Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare and Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx (PDP) plans. The joint enterprise is a Medicare approved Part D Sponsor. Enrollment in Blue MedicareRx (PDP) depends on contract renewal.

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## GET FINANCIAL HELP WITH YOUR PRESCRIPTION DRUG COSTS

People with limited income and resources may qualify for financial help to pay for their Medicare Part D prescription drug coverage premiums and out-of-pocket costs, such as deductibles, coinsurance, and copayments. To qualify for financial help, your income and resources must be below the amount defined each year.

To learn more about financial help that may be available to you:

- Call Vermont's Senior Helpline through Vermont Association of Area Agencies on Aging at (800) 642-5119.
- Visit the Prescription Assistance page for Department of Vermont Health Access at <https://dvha.vermont.gov/members/prescription-assistance>.
- Contact the Social Security Administration

## AVOIDING PART D LATE ENROLLMENT PENALTY

The Part D late enrollment penalty applies if you enroll in a Part D plan after your Medicare Initial Enrollment Period (IEP) ends. This lifetime penalty increases your monthly Part D premium. You can avoid this additional cost and penalty if you have creditable drug coverage (coverage similar in value to Part D) or qualify for Medicare's Extra Help Program. While Part D is optional, it's recommended that you enroll when first eligible.

If you do experience a late-enrollment penalty, CMS determines this amount and communicates that you and your Part D plan. To learn more about Medicare late enrollment penalties, visit [Medicare.gov](https://www.Medicare.gov).



# HOW TO ENROLL IN ADDITIONAL MEDICARE COVERAGE

Having complete Medicare coverage means enrolling in a Medicare Supplement plan, like Vermont Blue 65<sup>SM</sup>, and a Medicare Prescription Drug Plan (Part D). We understand this process can be complicated and are here to help you navigate your choices to determine what makes sense for you.

## 1 KNOWING WHEN TO ENROLL

- **Initial Enrollment Period (IEP)**
  - You're eligible to enroll three months before you turn 65, during your birthday month, or three months after the month you turn 65.
  - Please note, if your birthday falls on the first of the month, your Medicare IEP begins a month earlier. For instance, if your birthday is July 1, your Medicare IEP begins March 1.
- **Annual Enrollment Period (AEP)**
  - This enrollment period allows you to make changes to your Medicare Part D prescription drug plan. This enrollment period occurs yearly from **October 15** through **December 7**.

## 2 HOW TO ENROLL

We offer a few convenient ways to for you to enroll in Vermont Blue 65.

- **Enroll by phone.** Call us at **(800) 255-4550 (TTY/TDD: 711), option 4**.
- **Enroll online.** Visit [bluecrossvt.org/vtblue65](https://bluecrossvt.org/vtblue65) to complete our online enrollment form.
- **Enroll by mail.** Simply follow these steps to enroll by mail:
  - Enclose your signed application
  - Enclose a check made payable to Blue Cross Blue Shield of Vermont for the first month's payment of your desired plan choice
  - Enclose a photocopy of your Medicare card
  - Mail the items above in an envelope to us at:  
**Blue Cross and Blue Shield of Vermont**  
**P. O. Box 186**  
**Montpelier, VT 05601-0186**

To enroll in one of our Blue MedicareRx Prescription Drug Plans, visit [RxMedicarePlans.com](https://RxMedicarePlans.com), or call the Blue MedicareRX team at (888) 496-4178 (TTY: 711)

## CONTACT US

If you have questions, please reach out to us. We are available Monday — Friday, 8 a.m. to 4:30 p.m.

 Phone: **(800) 255-4550 (TTY/TDD: 711), option 4**

 Email: [consumersupport@bcbsvt.com](mailto:consumersupport@bcbsvt.com)

 Visit us online at [bluecrossvt.org/vtblue65](https://bluecrossvt.org/vtblue65)

# Disclaimers

## General Exclusions

A Medicare Supplement plan provides coverage designed to coordinate with your federal Medicare coverage. To fully understand a Medicare Supplement plan, you should read it alongside the Medicare Handbook, Medicare and You. We will provide Benefits as if you are enrolled in both Part A and Part B of Original Medicare and as if Medicare has paid its portion. You can find the Medicare and You handbook by visiting **Medicare.gov/Medicare-and-you**. Once you enroll, you will receive a Certificate of Coverage. Please read both carefully as they govern your specific benefits.

## How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at **bluecrossvt.org/privacypolicies**.

## NOTICE: Discrimination is Against the Law

BlueCross® and BlueShield® of Vermont (Blue Cross VT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-status.

Blue Cross VT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

Blue Cross VT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, contact Whitney Standefer-Smith, **civilrightscordinator@bcbsvt.com**

If you believe that Blue Cross VT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Whitney Standefer-Smith, Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583 (TTY/TDD: 711), fax (802) 229-0511, or email **civilrightscordinator@bcbsvt.com**. You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically or through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW Room 509F,  
HHH Building Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at  
**https://www.hhs.gov/ocr/complaints/index.html**

**For free language-assistance services, call (800) 247-2583 (TTY/TDD: 711).**

### ARABIC

للحصول على خدمات المساعدة اللغوية المجانية ، اتصل  
(800) 247 2583 (TTY/TTD: 711). lilhusul  
ealaa khadmat almusaadat allughawiat  
almajaanat, atasal (800) 247-2583  
(TTY/TDD: 711).

### CHINESE

如需免费语言协助服务，请致电，  
(800) 247-2583 (TTY/TDD: 711)。Rú xū  
miǎnfèi yǔyán xiézhù fúwù, qīng zhidiàn  
(800) 247-2583 TTY/TDD: 711).

### CUSHITE (OROMO)

Tajaajila gargaarsa afaanii bilisaa  
argachuuf, (800) 247-2583 (TTY/TDD: 711)  
bilbili.

### FRENCH

Pour des services d'assistance  
linguistique gratuits, appelez le  
(800) 247-2583 (TTY/TDD: 711).

### GERMAN

Für kostenlose  
Sprachunterstützungsdienste rufen Sie  
(800) 247-2583 (TTY/TDD: 711) an.

### ITALIAN

Per i servizi di assistenza linguistica  
gratuiti, chiamare il numero  
(800) 247-2583 (TTY/TDD: 711).

### JAPANESE

無料の言語支援サービスについては、  
(800) 247-2583 (TTY/TDD: 711)。  
Muryō no gengo shien sābisu ni tsuite  
wa, (800) 247-2583 (TTY/TDD: 711)  
made o denwa kudasai.

### NEPALI

निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल  
गर्नुहोस्, (800) 247-2583 (TTY/TDD: 711).  
Niḥśulka bhāṣā-sahāyatā sēvāharūkō  
lāgi, kala garnuhōs (800) 247-2583  
(TTY/TDD: 711).

### PORTUGUESE

Para serviços gratuitos de assistência  
linguística, ligue para (800) 247-2583  
TTY/TDD: 711).

### RUSSIAN

Чтобы получить бесплатную языковую  
помощь, позвоните по телефону  
(800) 247-2583 (TTY/TDD: 711).

### SERBO-CROATIAN (SERBIAN)

Za besplatne usluge jezičke  
pomoći pozovite (800) 247-2583  
(TTY/TTD: 711). Za besplatne  
usluge jezičke pomoći pozovite  
(800) 247-2583 (TTY/TDD: 711).

### SPANISH

Para servicios gratuitos de  
asistencia lingüística, llame al  
(800) 247-2583 (TTY/TDD: 711).

### TAGALOG

PAUNAWA: Kung nagsasalita ka  
ng Tagalog, maaari kang gumamit  
ng mga serbisyo ng tulong sa wika  
nang walang bayad. Tumawag sa  
(800) 247-2583 (TTY/TDD: 711).

### THAI

สำหรับการบริการช่วยเหลือด้านภาษาฟรี โทร,  
(800) 247-2583 (TTY/TDD: 711). Sǎhṙāp  
brikār chwyhelṙāx dān phās'ā frī thor  
(800) 247-2583 (TTY/TDD: 711).

### UKRAINIAN

Щоб отримати безкоштовні мовні  
послуги, телефонуйте (800) 247-2583  
(TTY/TDD: 711). Shchob otrymaty  
bezkoshtovni movni posluhy, telefonuyte  
(800) 247-2583 (TTY/TDD: 711)

### VIETNAMESE

Đối với các dịch vụ hỗ trợ ngôn ngữ  
miễn phí, hãy gọi  
(800) 247-2583 (TTY/TDD: 711).

# VERMONT BLUE 65<sup>SM</sup> OUTLINE OF COVERAGE

for Plans A, D, G, and N  
and Plans C and F for applicants first eligible  
for Medicare before January 1, 2020

If you have questions about our Medicare  
Supplement plans, call our team at  
(800) 255-4550 (TTY/TDD: 711).



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, 2026

## Direct Enroll Monthly Rate

Plan A Individual:	\$290.88
Plan D Individual:	\$399.16
Plan G Individual:	\$399.98
Plan N Individual:	\$369.95
Plan C Individual**:	\$424.98
Plan F Individual**:	\$425.77

**\*\* Note:** Plan C and Plan F are only available to applicants who were first eligible for Medicare before January 1, 2020.

# Disclosures

## Premium Information

We, Blue Cross and Blue Shield of Vermont, 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 Blue Cross and Blue Shield of Vermont.

## Right to Return Certificate

If you find that you are not satisfied with your certificate, you may return it to Blue Cross and Blue Shield of Vermont, P.O. Box 186, Montpelier, VT 05601-0186 or call (800) 255-4550 (TTY/TDD: 711). 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.
- Blue Cross and Blue Shield of Vermont 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, 2026)

This chart shows the benefits included in each of the standard Medicare supplement plans. Blue Cross® and Blue Shield® of Vermont offers Plans A, D , G and N as well as Plans C and F for applicants first eligible for Medicare before January 1, 2020.

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

Benefits	Plans Available to All Applicants								Medicare first eligible before January 1, 2020 only	
	A	B	D	G <sup>1</sup>	K	L	M	N <sup>3</sup>	C	F <sup>1</sup>
Medicare Part A co-insurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply <sup>3</sup>	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	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 2026 <sup>2</sup>					\$8,000 <sup>2</sup>	\$4,000 <sup>2</sup>				

<sup>1</sup>Plans F and G also have a high deductible option which require first paying a plan deductible of \$2,950 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.

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

<sup>3</sup>Plan N pays 100% of the Medicare Part B coinsurance after you meet your Medicare Part B deductible. After you pay your full Medicare Part B deductible, you may pay up to a \$20 copayment for each office visit and up to a \$50 copayment for an emergency room visit if it does not result in an inpatient admission.

# PLAN A

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies.			
– First 60 days	All but \$1,736	\$0	\$1,736 (Part A deductible)
– 61st through 90th day	All but \$434 a day	\$434 a day	\$0
– 91st day and after, while using 60 lifetime reserve days	All but \$868 a day	\$868 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 \$217 a day	\$0	Up to \$217 a day
– 101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$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
<b>MEDICAL EXPENSES</b> 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 \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
Tests for diagnostic services	100%	\$0	\$0

## MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT:</b> – First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

\* Once you have been billed \$283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Medicare 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
– First 60 days	All but \$1,736	\$1,736 (Part A deductible)	\$0
– 61st through 90th day	All but \$434 a day	\$434 a day	\$0
– 91st day and after, while using 60 lifetime reserve days	All but \$868 a day	\$868 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 \$217 a day	Up to \$217 a day	\$0
– 101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$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
<b>MEDICAL EXPENSES</b> 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 \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (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
<b>BLOOD</b>			
First three pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
Tests for diagnostic services	100%	\$0	\$0

## MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT:</b> – First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

## OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL (Not Covered By Medicare)</b> 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 \$283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Medicare 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
<b>HOSPITALIZATION*</b>			
<b>SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MISCELLANEOUS SERVICES AND SUPPLIES</b>			
– First 60 days	All but \$1,736	\$1,736 (Part A deductible)	\$0
– 61st through 90th day	All but \$434 a day	\$434 a day	\$0
– 91st day and after, while using 60 lifetime reserve days	All but \$868 a day	\$868 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 \$217 a day	Up to \$217 a day	\$0
– 101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$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
<b>MEDICAL EXPENSES</b>			
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 \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)**	\$0	100%	\$0
<b>BLOOD</b>			
First three pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
Tests for diagnostic services	100%	\$0	\$0

## MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment: – First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (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
<b>FOREIGN TRAVEL (Not Covered By Medicare)</b>			
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 \$283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Medicare 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
<b>HOSPITALIZATION*</b>			
<b>SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MISCELLANEOUS SERVICES AND SUPPLIES</b>			
– First 60 days	All but \$1,736	\$1,736 (Part A deductible)	\$0
– 61st through 90th day	All but \$434 a day	\$434 a day	\$0
– 91st day and after, while using 60 lifetime reserve days	All but \$868 a day	\$868 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 \$217 a day	Up to \$217 a day	\$0
– 101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$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
<b>MEDICAL EXPENSES</b>			
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 \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	**
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)**	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
Tests for diagnostic services	100%	\$0	\$0

## MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment: – First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

## OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL (Not Covered By Medicare)</b>			
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 \$283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Medicare Part B deductible will have been met for the calendar year.

\*\* After you pay your full Medicare Part B deductible, you may pay up to a \$20 copayment for each office visit and up to a \$50 copayment for an emergency room visit if it does not result in an inpatient admission.



# PLAN C

for applicants first eligible for Medicare before January 1, 2020

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
– First 60 days	All but \$1,736	\$1,736 (Part A deductible)	\$0
– 61st through 90th day	All but \$434 a day	\$434 a day	\$0
– 91st day and after, while using 60 lifetime reserve days	All but \$868 a day	\$868 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 \$217 a day	Up to \$217 a day	\$0
– 101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$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 January 1, 2020

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES</b> 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 \$283 of Medicare-approved amounts*	\$0	\$283 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$283 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
Tests for diagnostic services	100%	\$0	\$0

## MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment: – First \$283 of Medicare-approved amounts*	\$0	\$283 (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
<b>FOREIGN TRAVEL (Not Covered By Medicare)</b> 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 \$283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Medicare Part B deductible will have been met for the calendar year.

PLAN F

for applicants first eligible for Medicare before January 1, 2020

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
– First 60 days	All but \$1,736	\$1,736 (Part A deductible)	\$0
– 61st through 90th day	All but \$434 a day	\$434 a day	\$0
– 91st day and after, while using 60 lifetime reserve days	All but \$868 a day	\$868 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 \$217 a day	Up to \$217 a day	\$0
– 101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$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 January 1, 2020

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES</b> 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 \$283 of Medicare-approved amounts*	\$0	\$283 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)**	\$0	All costs	\$0
<b>BLOOD</b>			
First three pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$283 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
Tests for diagnostic services	100%	\$0	\$0

MEDICARE PARTS A & B			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment: – First \$283 of Medicare-approved amounts*	\$0	\$283 (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
<b>FOREIGN TRAVEL (Not Covered By Medicare)</b> 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 \$283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Medicare 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.



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