<table>
<thead>
<tr>
<th>SERVICES</th>
<th>MEDICARE PAYS</th>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOSPITALIZATION</strong> * **</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semiprivate room and board, general nursing and miscellaneous services and supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– First 60 days</td>
<td>All but $1,184</td>
<td>$1,184</td>
<td>$0</td>
</tr>
<tr>
<td>– 61st through 90th day</td>
<td>All but $296</td>
<td>$296 a day</td>
<td>$0</td>
</tr>
<tr>
<td>– 91st day and after, while using 60 lifetime reserve days</td>
<td>All but $592 a day</td>
<td>$592 a day</td>
<td>$0</td>
</tr>
<tr>
<td>– Once lifetime reserve days are used: additional 365 days</td>
<td>$0</td>
<td>100% of Medicare eligible expenses</td>
<td>$0</td>
</tr>
<tr>
<td>– Beyond the additional 365 days</td>
<td>$0</td>
<td>$0</td>
<td>All costs</td>
</tr>
<tr>
<td><strong>SKILLED NURSING FACILITY CARE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– First 20 days</td>
<td>All approved amounts</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>– 21st through 100th day</td>
<td>All but $148 a day</td>
<td>Up to $148 a day</td>
<td>$0</td>
</tr>
<tr>
<td>– 101st day and after</td>
<td>$0</td>
<td>$0</td>
<td>All costs</td>
</tr>
<tr>
<td><strong>BLOOD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First three pints</td>
<td>$0</td>
<td>All costs</td>
<td>$0</td>
</tr>
<tr>
<td>Additional amounts</td>
<td>100%</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>HOSPICE CARE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</td>
<td>All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care</td>
<td>Medicare co-payment/co-insurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

* 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.
## MediComp III

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

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>MEDICARE PAYS</th>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICAL EXPENSES</strong> 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</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First $147 of Medicare-approved amounts*</td>
<td>$0</td>
<td>$147</td>
<td>$0</td>
</tr>
<tr>
<td>Remainder of Medicare-approved amounts</td>
<td>Generally 80%</td>
<td>Generally 20%</td>
<td>$0</td>
</tr>
<tr>
<td>Part B excess charges (above Medicare-approved amounts)</td>
<td>$0</td>
<td>$0</td>
<td>All costs</td>
</tr>
<tr>
<td><strong>BLOOD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First three pints</td>
<td>$0</td>
<td>All costs</td>
<td>$0</td>
</tr>
<tr>
<td>Next $147 of Medicare-approved amounts*</td>
<td>$0</td>
<td>$147</td>
<td>$0</td>
</tr>
<tr>
<td>Remainder of Medicare-approved amounts</td>
<td>80%</td>
<td>20%</td>
<td>$0</td>
</tr>
<tr>
<td><strong>CLINICAL LABORATORY SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood tests for diagnostic services</td>
<td>100%</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Medicare Parts A & B

#### HOME HEALTH CARE

Medicare-approved services

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>MEDICARE PAYS</th>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically necessary skilled care services and medical supplies</td>
<td>100%</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>$0</td>
<td>$147</td>
<td>$0</td>
</tr>
<tr>
<td>First $147 of Medicare-approved amounts*</td>
<td>$0</td>
<td>$147</td>
<td>$0</td>
</tr>
<tr>
<td>Remainder of Medicare-approved amounts</td>
<td>80%</td>
<td>20%</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Other Benefits — Not Covered by Medicare

#### FOREIGN TRAVEL (Not Covered By Medicare)

Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>MEDICARE PAYS</th>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>First $250 each calendar year</td>
<td>$0</td>
<td>$0</td>
<td>$250</td>
</tr>
<tr>
<td>Remainder of charges</td>
<td>$0</td>
<td>80%</td>
<td>20% and amounts over the $50,000 lifetime maximum</td>
</tr>
</tbody>
</table>

*Once you have been billed $147 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.*
Offered by The Vermont Health Plan

Examination Right
You have the right to return this certificate within 30 days of its delivery and to have your subscription rate refunded (reduced by any claims payable) if, after examination of this Certificate, you are not satisfied for any reason.

Agreement
By paying for and accepting this Contract, you are entitled to Benefits under the terms and conditions explained in this document. Coverage begins on the effective date and continues until the Contract is terminated.

Subscription Payments
You must pay the initial subscription rate on or before the effective date of this Contract. This Contract will not be in force until we receive and accept your initial subscription payment. We reserve the right to change your subscription rates and will notify you in advance of any change. Your rates must be approved by the Vermont Department of Financial Regulation.

Note to Buyer:
This coverage may not cover all of your medical expenses.

Plan C Certificate of Coverage

Renewal
We guarantee that you may renew this Contract for further consecutive periods by paying the subscription rate as specified in Section Eleven herein and within the grace period provided in Section Ten.

Karen Nystrom-Meyer
Chair of the Board

Don C. George
President and CEO

Christopher R. Gannon
Vice President, General Counsel & Chief Administrative Officer, Assistant Treasurer/Secretary

280.259 (11/2010)
Introduction
This Certificate provides coverage designed to coordinate with your federal Medicare coverage. To fully understand this Certificate, you should read it alongside the Medicare handbook, Medicare and You. Except for the terms defined in Section One, all terms used in this Certificate are used as defined in Medicare and You. We will provide Benefits as if you are enrolled in both Part A and Part B of Medicare and as if Medicare has paid its portion.

Section One
General Definitions
These terms have special meaning. All defined terms except “You,” “Your,” “We,” “Us,” and “Our” are capitalized in the text of the document to show that they convey the meaning defined here.

**Contract** (consists of):
- the Outline of Coverage;
- this Certificate;
- any supplements and endorsements issued by us;
- your Identification Card; and
- your application and any supplemental applications submitted by you and approved by us.

**Benefit**: the amount we pay for a covered service or supply as shown on your Explanation of Benefits.

**Benefit Period**: a Medicare 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.

**Medicaid**: medical assistance under Title XIX of the Social Security Act.

**Providers**: physicians, hospitals, skilled nursing facilities, home health agencies and other Providers approved by Medicare or approved by us for services under this Contract.

**Totally Disabled (Total Disability)**: a condition caused by disease or injury that we determine has resulted in your inability to perform all the substantial and material duties of your regular occupation or to perform the normal activities of a person of like age and sex. You cannot be engaged in any employment or occupation for wage or profit and be considered totally disabled. Also, you must be under the regular care and attendance of a physician.

**You, Your**: the individual who is entitled to Medicare, who has applied for and been accepted for Vermont Medigap Blue and whose name appears on the Identification Card issued by us.

**We, Us and Our**: The Vermont Health Plan or its designated agent(s).

Section Two
Benefits for Covered Services
Core Benefits

**Co-insurance for Hospitalization (61st–90th Day)**
We provide Benefits for Medicare Part A-eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

**Co-insurance for Hospitalization (During Reserve Days)**
We provide Benefits for Medicare Part A-eligible expenses incurred for hospitalization, to the extent not covered by Medicare, for each Medicare lifetime inpatient reserve day used.

**Hospitalization (Additional Reserve Days)**
When you exhaust Medicare hospital inpatient coverage, including your lifetime reserve days, we provide Benefits for Medicare Part A-eligible expenses for hospitalization, subject to a lifetime maximum Benefit of an additional 365 days. Your Provider must accept our allowance as payment in full and may not bill you for any balances between our payment and the full charge.

**Blood**
We provide Benefits for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) you receive per calendar year. (Note: Refer to your
Medicare Handbook for more information on “non-replacement fees” and how you may replace any blood you may have used.

Part B Co-insurance and Co-payments
After your Medicare Part B deductible is paid, we provide Benefits for your co-insurance and/or co-payment share of Medicare-eligible expenses under Part B, regardless of hospital confinement.

Hospice Care Benefit
We will pay the co-payment and co-insurance amounts for all hospice care and respite care expenses approved by Medicare.

Plan C Additional Benefits

Medicare Part A Deductible
We provide Benefits for the Medicare Part A inpatient hospital deductible amount for each Medicare Benefit Period.

Skilled Nursing Facility Care Co-insurance
We provide Benefits for your co-insurance share from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital care in a Medicare-eligible skilled nursing facility. If the actual billed charges are less than your co-insurance share, we will pay the actual billed charge.

Medicare Part B Deductible
We provide Benefits for the Medicare Part B deductible amount for each calendar year, regardless of hospital confinement.

Medically Necessary Emergency Care in a Foreign Country
We provide limited Benefits for emergency care you receive in a foreign country when these services are not covered by Medicare. After you pay a $250 deductible, we pay 80% of the billed charges for Medicare-eligible expenses to a lifetime maximum Benefit of $50,000 (U.S.) under the following conditions:

- we consider your hospital, physician and medical care medically necessary and an emergency;
- your care would have been covered by Medicare if it were provided in the United States; and
- your care begins during the first sixty (60) consecutive days of a trip outside the United States.

For purposes of this Benefit, “emergency care” means care needed immediately because of an injury or an illness of sudden and unexpected onset.

Limitations and Exclusions

Limitations
We only provide Benefits for approved Medicare-eligible services provided on or after the effective date of this Contract.

Exclusions
No Benefits will be provided for services and supplies not specifically covered in this Contract.

Section Four
Provider Relationships
The choice of a Provider is solely yours. We are not liable for any act, omission or refusal to act by any Provider. Also, we do not guarantee the availability of any Provider. We do not furnish services, but only provide Benefits for services covered under this Contract.

Section Five
Claim Filing
Remember, when you contact a Provider, it is your responsibility to:

- identify yourself as having Medicare coverage; and
- identify yourself as having supplemental coverage with The Vermont Health Plan.

Claim Submission
In most cases, your Provider will submit your claim to Medicare. Medicare, in turn, will submit your processed claim to us electronically. This means that, in most cases, you will not have to submit a claim to us.

If you receive services in a foreign country, you are required to submit your claims directly to us. Do not send these claims to Medicare first.
We must receive all claims eligible to be processed by Medicare within one calendar year after you receive the service. Claims received after this date are ineligible for Benefits.

You may obtain claim forms from us by calling our customer service department or visiting our website at www.bcbsvt.com.

**Release of Information**

We need specific information in order to administer your Benefits. This information includes records, copies of records and verbal statements. By accepting this Contract, you give us the right to obtain from any source all information we need to administer your Benefits. We also have the right to obtain this information to perform utilization review studies and analyses of Benefit programs. Our approval of your Benefits is conditional upon your furnishing us with such information, even if we provide Benefits before we obtain the information.

In order to avoid duplicate payments, we may furnish this information to other entities who provide similar Benefits, unless otherwise prohibited by law.

*Section Six*

**Benefit Determination and Payments**

**Benefit Determination**

When we receive your claim, we determine:

- whether this Contract covers your services; and
- your Benefit amount.

Your Vermont Medigap Blue Explanation of Benefits shows your Benefit.

**Benefit Payments**

We usually pay:

- Medicare-participating Providers directly; and
- you directly for services you receive from other Providers (however, we reserve the right to pay any Provider directly).

Your rights under this Contract are personal. This means that you may not assign your Benefit rights to any other party.

**Payment In Error**

If we pay Benefits incorrectly to you, we require you to repay us any overpayment. We will send you written notice requesting a refund. If we pay your Provider incorrectly, we reserve the right to seek reimbursement. In either case, your future Benefits may be reduced or withheld to recover incorrect payments made to you or your Provider.

Regardless of whether we seek recovery, erroneous payments on one occasion will not obligate us to provide Benefits on another occasion.

**Claim Review and Appeal**

You may request a review of how we determined your Benefit by contacting our customer service center. You must, however, request this review within 60 days after we mail your Explanation of Benefits.

Remember, whenever you contact us, please note:

- your certificate number as shown on your Identification Card;
- the date of the service in question; and
- the number of the claim as it appears on your Explanation of Benefits.

If you do not agree with the results of the claim review, you may request a claim appeal. If, however, you have a claim appeal pending with Medicare, please don’t notify us until Medicare has resolved the appeal. You must make this appeal within 60 days after we mail you the results of the claim review. Send your appeal with the information noted above and any comments, in writing to:

Claim Appeal Committee
The Vermont Health Plan
P. O. Box 186
Montpelier, Vermont 05601-0186

You have the right to review data related to your appeal. We usually review your claim appeal and mail you a written decision within 60 days after we receive your appeal. If, however, we determine that a more extensive review is necessary, we will notify you that a decision will be made within 120 days.

The written decision of the claim appeal committee is our final determination of your Benefits. By accepting this Contract, you agree to seek a decision of the claim appeal committee before taking any judicial action.
Section Seven

Other Insurance Coverage Prohibited

You may not obtain any other supplemental health insurance coverage, including Medicaid, if you are covered under this Contract.

Suspension of Coverage

If you become eligible for Medicaid, you may suspend this coverage for up to 24 months. To do this, you must notify us within 90 days after you are determined Medicaid-eligible. If this occurs, we will refund any amount of unearned prepaid subscription fees.

If within 24 months, you are no longer eligible for Medicaid, you may be reinstated under this Contract if:

- you notify us within 90 days of the loss of Medicaid eligibility; and
- you pay the subscription rate due from the date of loss of Medicaid.

If you are entitled to Benefits under Section 226(b) of the Social Security Act and covered under a group health plan, we will suspend Benefits and subscription fees under this policy at your request. This suspension of coverage can last as long as the period provided by federal regulation.

Upon our receipt of your timely notification, we will refund any unearned prepaid subscription fees for the period of time you are covered under the group health plan. Your refunded premium will be reduced by the amount of any claims paid for the period you are eligible.

If you lose coverage under the group health plan during this suspension of coverage, your policy will be automatically reinstated as long as you notify us of such loss of coverage within 90 days after it occurs. We will automatically restate your coverage effective on the date the group health plan terminated. You must pay the applicable subscription rate. Upon reinstatement, we will:

- provide coverage substantially equivalent to the coverage in effect prior to the date of suspension; and
- charge the rate approved at that time.

Section Eight

Subrogation

To the extent that we pay or are obligated to pay Benefits under your Contract, we shall be subrogated to your rights of recovery from any person or organization that caused or contributed to your illness or injuries or paid or should pay as a result of your illness or injuries. This means that:

- If you receive health care Services for injuries or illness, and we pay Benefits for any part of those Services, you shall pay us all amounts you recover by suit, settlement or otherwise from any third party, its insurer or your insurer, to the extent of the Benefits paid under your Contract. You are required to reimburse us whether or not you have been “made whole” by the recovery from the third party or insurer. In appropriate cases, we will reduce the amounts you owe us by a proportionate share of the reasonable attorneys’ fees and costs incurred by you to obtain your recovery.

- We reserve the right to bring a lawsuit in your name or in our name against any responsible party or parties to recover Benefits we have advanced or to settle our claim for such Benefits with such responsible party or parties.

- This right of subrogation includes any recovery you may have under no-fault auto insurance, group auto insurance, traditional fault-type auto insurance, uninsured or underinsured motorist insurance, automobile-medical payment insurance, homeowners insurance, personal injury protection insurance, financial responsibility insurance, medical reimbursement insurance coverage that you did not purchase, or any other property and liability insurance providing medical payment Benefits.

- You shall take such action, furnish such information and assistance, and execute such papers (including a reimbursement agreement) as we may require to enforce our rights, and you shall take no action prejudicing our rights and interests under your Contract.
Section Nine

Membership

Eligibility

This Contract is specifically intended for only those individuals enrolled in Parts A and B of Medicare.

Effective Date of Coverage

Your enrollment under this Contract begins on the effective date shown on our records unless you are hospitalized on that date. If you are hospitalized on the membership effective date, your effective date is on the hospital discharge date.

Section Ten

Termination of Coverage

You or your group may terminate this Contract without cause at the end of any calendar month by giving 15 days prior written notice. We may terminate this Contract due to:

- nonpayment;
- fraud or misrepresentation;
- failure to maintain Parts A and B of Medicare;
- residency outside of the United States for more than six months; or
- discontinuation of this product.

Upon Contract termination, we will refund to you any unearned prepaid subscription rates we hold. Such payment constitutes a full and final discharge of all our obligations under this Contract, unless otherwise required by law. We will continue to provide Benefits for all covered services received before the date of termination.

Default in Subscription Payment

If we do not receive your payment within ten days after it is due:

- we will mail you a cancellation notice; and
- this Contract will automatically terminate at midnight of the 14th day after we send you a cancellation notice.

Termination for nonpayment is considered cancellation by you.

Fraud, Misrepresentation or Concealment of a Material Fact

If you obtain or attempt to obtain coverage or Benefits through fraud, including material misrepresentation or concealment of a material fact, this Contract is void. You will be permanently disenrolled. If you are disenrolled due to fraud, we will not provide any extension of Benefits after this Contract is terminated.

Any misrepresentation on your application for coverage shall void this Contract if discovered within three years of the effective date. After you have been enrolled for three years, only fraudulent misstatements made on your application shall be used to void this Contract or as a basis to deny a claim.

If you commit fraud, we are entitled to all remedies provided by law and in equity, including, but not limited to, recovery from you for the charges for Benefits provided, attorneys’ fees, costs of suit and interest.

Warning: It is a crime punishable by fines and imprisonment under Vermont law to present a claim for payment or Benefit under this Contract that contains false representations or which conceals material information.

Contract Reinstatement

We may reinstate a terminated Contract solely at our discretion and only on such terms and conditions as we decide, as allowed by law. Please note that if you terminate this coverage, you may need to pay more for coverage at a future date.
Voidance and Modification

No representation by you on your application for a Contract shall make this Contract void, or be used in any legal proceeding under this Contract unless your application or an exact copy of it is included in or attached to your Contract.

Only an officer of The Vermont Health Plan is authorized to bind us legally by changing or waiving any provisions of this Contract.

Benefits After Termination of Coverage

If you are an inpatient when your coverage terminates, we will continue to provide Benefits under this Contract for facility services related to your inpatient stay until:
- your inpatient stay ends;
- you exhaust your Benefit maximums; or
- you become covered elsewhere for your inpatient condition;
whichever occurs first.

If, however, you are entitled to Benefits for a continuous Total Disability existing on the cancellation date, we provide Benefits for services until the earlier of:
- the end of your Benefit Period; or
- the date Benefits available to you under this Contract are exhausted.

Section Eleven

General Contract Provisions

Applicable Law

This Contract is intended for sale and delivery in, and is subject to the laws of, the State of Vermont.

Entire Agreement

Your Contract is the entire agreement between you and us. You shall have no rights or privileges not specifically provided in this Contract. This Contract may only be changed in writing and with the approval of the Vermont Department of Financial Regulation. Notification of any change in this Contract will be in accordance with applicable law.

Non-Waiver of Our Rights

Occasionally, we may choose not to enforce certain terms or conditions of this Contract. This does not mean we give up the right to enforce these terms or conditions later.

Term of Contract

Coverage continues from month to month until this Contract is discontinued, terminated or voided as allowed by this Contract.

Subscription Rate

Your subscription rate is payable in advance directly to us. We allow no more than a ten-day grace period for payment.

Your rate has been filed with and approved by the Vermont Department of Financial Regulation. We may change rates only if we receive approval from the Vermont Department of Financial Regulation. We will notify you of any rate change in accordance with state law.

Each year, the co-insurance and/or deductible amounts established by Medicare may change and this coverage will change with them. Therefore, in order to allow continued coverage of the full deductibles and co-insurance amounts as specified in Section Two, the rates charged for this Contract may be adjusted, as appropriate, and as approved by the Vermont Department of Financial Regulation.

Your Address

You must notify us, in writing, of any change of address.

We send all notices by first class postage to your address that we have on file. This constitutes our full responsibility to notify you, regardless of whether you receive such notice.
Information about your Medicare Supplement Plan C Coverage

Please read carefully.