

\$20 PCP/\$20 Specialist co-payment

Pharmacy: \$25 deductible, 10% co-insurance / 20% co-insurance / 40% co-insurance

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period Begins: 01/01/2014

Coverage For: State of Vermont Plan Type: POS



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <http://humanresources.vermont.gov/salary/benefits/open-enrollment> or by calling (888) 778-5570.

Important Questions	Answers	Why this matters:
What is the overall deductible ?	<p>\$0 individual / \$0 family preferred provider. \$500 individual / \$1,000 family non-preferred provider.</p> <p>At least one family member must satisfy the individual deductible. Co-insurance and co-payments do not count towards the deductible. Preferred services do not apply to the non-preferred deductible. Does not apply to non-preferred preventive mammography screenings.</p> <p>Does not apply to prescription drugs.</p>	See the chart starting on page 2 for your costs for services this plan covers. The plan pays benefits when an individual or the family meets the deductible. If the Plan option selected has in-network and out-of-network deductibles, eligible medical expenses incurred from out-of-network providers will be applied toward their in-network and the out-of-network deductibles. Eligible medical expenses incurred from in-network providers will only be applied toward the in-network deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2014 through 12/31/2014. We apply any portion of your deductible that you pay for services occurring after September 30 each plan year towards your next year's deductible as well.
Are there other deductibles for specific services?	Yes. \$25 individual / \$75 family prescription drug deductible.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	<p>Yes. \$0 individual / \$0 family preferred provider. \$2,000 individual / \$6,000 family non-preferred provider.</p> <p>Prescription drugs are limited to \$775 per individual. Excludes non-preferred prescription drug costs.</p>	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, out-of-network mental health and substance abuse co-insurance and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.

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Does this plan use a network of providers ?	Yes. For a list of Participating providers see www.bcbsvt.com/findadoctor or call (888) 778-5570.	If you use an in-network doctor or other health care provider this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 co-payment per visit for primary care physician and mental health / substance abuse	30% co-insurance*	Some services require prior approval. For clarification on mental health services visit www.bcbsvt.com/mental-health-primary-care .
	Specialist visit	\$20 co-payment per visit	30% co-insurance*	Some services require prior approval.

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		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Other practitioner office visit	\$20 co-payment per visit for chiropractic care, nutritional counseling, outpatient physical, speech, and occupational therapy	30% co-insurance* for chiropractic care, nutritional counseling, outpatient physical, speech, and occupational therapy	Some services require prior approval. Frequency limits apply. Outpatient physical, occupational, speech, massage therapy and chiropractic care are covered up to 60 visits combined.
	Preventive care / Screening / Immunization	No charge	30% co-insurance*; no charge mammogram screening	For clarification on preventive services visit www.bcbsvt.com/preventive .
If you have a test	Diagnostic test (x-ray, blood work)	No charge for office-based and outpatient hospital	30% co-insurance* for office-based and outpatient hospital	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	No charge	30% co-insurance*	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is at www.express-scripts.com .	Generic drugs	\$25 deductible, then 10% co-insurance	Not covered	Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	\$25 deductible, then 20% co-insurance	Not covered	Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	\$25 deductible, then 40% co-insurance	Not covered	Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval.

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		Preferred Provider	Non-Preferred Provider	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is at www.bcbsvt.com/rxcenter .	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% co-insurance*	Some services require prior approval.
	Physician/surgeon fees	No charge	30% co-insurance*	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$50 co-payment per visit for facility services; no charge for physician services	\$50 co-payment per visit for facility services; no charge for physician services	Must meet emergency criteria.
	Emergency medical transportation	No charge	No charge	Must meet emergency criteria.
	Urgent care	\$50 co-payment per visit	\$50 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 co-payment per admission	30% co-insurance*	Requires prior approval.
	Physician/surgeon fee	No charge	30% co-insurance*	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	30% co-insurance*	Some services require prior approval.
	Mental/Behavioral health inpatient services	No charge	30% co-insurance*	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge	30% co-insurance*	Some services require prior approval.
	Substance use disorder inpatient services	No charge	30% co-insurance*	Includes facility and physician fees. Requires prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you are pregnant	Prenatal and postnatal care	No charge	30% co-insurance*	None
	Delivery and all inpatient services	\$250 co-payment per admission	30% co-insurance*	Requires prior approval.
If you need help recovering or have other special health needs	Home health care	No charge	30% co-insurance*	Home infusion therapy requires prior approval.
	Rehabilitation services	No charge inpatient; \$20 co-payment cardiac / pulmonary services	30% co-insurance*	Inpatient rehabilitation services require prior approval. Frequency limits apply. Cardiac rehabilitation exercise sessions covered up to three per week for up to 12 weeks per event.
	Habilitation services	No charge for inpatient services	30% co-insurance* inpatient services	None
	Skilled nursing care (facility)	No charge	30% co-insurance	Requires prior approval. Covered up to 60 days.
	Durable medical equipment (including supplies)	No charge	30% co-insurance*	May require prior approval.
	Hospice	No charge	30% co-insurance*	None
If your child needs dental or eye care	Eye exam	Exam and lenses covered up to \$100 per adult; no limit per child	Exam and lenses covered up to \$100 per adult; no limit per child	One routine exam every 24 months.
	Glasses	Exam and lenses covered up to \$100 per adult; no limit per child	Exam and lenses covered up to \$100 per adult; no limit per child	One pair of lenses every 24 months.
	Dental check-up	Not covered	Not covered	None

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check the policy or plan document for other [excluded services](#).)

- Cosmetic Surgery (except with prior approval for reconstruction)
- Long-term care
- Weight loss programs
- Dental care (child and adult)
- Private-duty nursing
- Hearing aids
- Routine foot care (except for treatment of diabetes)

Other Covered Services (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Infertility Medications
- Bariatric Surgery
- Non-emergency care when traveling outside the U.S. (www.bcbsvt.com/coveragewhiletraveling)
- Chiropractic Care
- Routine eye care (one routine eye exam per child and adult member every 24 months)

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (800) 255-4550.

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Coverage Examples

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$7,120
- **Patient pays :** \$420

Sample care costs:

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$20
Co-pays	\$250
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$420

Managing type 2 diabetes
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$4,810
- **Patient pays :** \$590

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$30
Co-pays	\$200
Coinsurance	\$280
Limits or exclusions	\$80
Total	\$590

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Custom Summary Name: BCBS-POS-x-x-x-x-20-20-50-0-0-0-GF-LARG (MD16317)_BCBS-Rx-25-x-x-10%-20%-40%-2-x-P(RX15992)_Coverage-012014-12312014(C15340)_Q4 - ACA(RD13554) wQ4ACA CY 1016071

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