BCBSVT Blue Rewards Silver Plan

$30 PCP / $50 Specialist co-payment, $200 / $400 Deductible
Pharmacy: $5 co-payment / 40% co-insurance / 60% co-insurance
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period Begins: 01/01/2017
Coverage For: All **Plan Type:** EPO

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 www.bcbsvt.com/nonstd-copay-cert or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall **deductible**?	$200 individual / $400 family aggregate. Co-insurance and co-payments do not count towards the deductible. Deductible and co-payments do not apply to preventive care, dental class I or the first three primary care, mental health and substance abuse office visits (including routine lab services) combined up to a total of nine visits per family. This benefit combines your prescription drug and medical deductibles. *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles, out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2017 through 12/31/2017.
Are there other **deductibles** for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an **out-of-pocket limit** on my expenses?	Yes. $2,250 individual plan. Family plans have an individual out-of-pocket limit of $2,250 and $4,500 aggregate family. Prescription drugs: $1,300 individual plan / $2,600 family aggregate. Medical and prescription drug out-of-pocket limits are combined.	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, adult vision care, adult dental services 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.
Does this plan use a **network** of **providers**?	Yes. For a list of network providers see www.bcbsvt.com/findadoctor or call (800) 255-4550.	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.

Important Questions	Answers	Why this matters:
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 In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$30 co-payment* per visit for primary care physician and mental health / substance abuse	Not covered	Some services require prior approval. Deductible and co-payments do not apply to some services see www.bcbsvt.com/ nonstd-copays for more information. For clarification on mental health services visit www.bcbsvt.com/mental-health-primary-care.
	Specialist visit	$50 co-payment* per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	$50 co-payment* per visit for chiropractic services, nutritional counseling, outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit www.bcbsvt.com/preventive.

Questions: Call (800) 255-4550 or visit us at www.bcbsvt.com/nonstd-copay-cert. If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at www.bcbsvt.com/glossary or call (800) 255-4550 to request a copy. *Deductible applies to these services.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	$50 co-payment* per visit for office-based and outpatient hospital	Not covered	Some services require prior approval. Deductible and co-payments do not apply to some services see www.bcbsvt.com/nonstd-copays for more information.
	Imaging (CT/PET scans, MRIs)	$500 co-payment* per visit	Not covered	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is at www.bcbsvt.com/rxcenter.	Generic drugs	$5 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	40% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	60% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 co-payment* per visit	Not covered	Some services require prior approval.
	Physician/surgeon fees	No charge*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	$250 co-payment* per visit for facility services; no charge* for physician services	$250 co-payment* per visit for facility services; no charge* for physician services	Must meet emergency criteria.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency medical transportation	$50 co-payment* per member per day	$50 co-payment* per member per day	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)	$500 co-payment* per admission	Not covered	None
	Physician/surgeon fee	No charge*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	No charge*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	$500 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	$500 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	$30 co-payment* per visit	Not covered	Other services and tests may take additional cost-sharing. No charge for in-network care considered preventive. For a list of services visit www.bcbsvt.com/preventive.
	Delivery and all inpatient services	$500 co-payment* per admission	Not covered	None
If you need help recovering or have other special health needs	Home health care	$50 co-payment* per visit	Not covered	Home infusion therapy requires prior approval. Frequency limits apply.
	Rehabilitation services	$500 co-payment* per inpatient admission; no charge* for cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Habilitation services	$500 co-payment* per inpatient admission	Not covered	Requires prior approval. Frequency limits apply.
	Skilled nursing care (facility)	$500 co-payment* per admission	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	$50 co-payment*	Not covered	May require prior approval.
	Hospice	No charge*	Not covered	None
If your child needs dental or eye care	Eye exam	$50 co-payment* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	$50 co-payment* for child glasses; 100% of charges for adult glasses	Not covered	One pair of exchange-level frames and lenses for prescription glasses or one pair of equivalent contact lenses per calendar year.
	Dental check-up	Child: Class I: No charge, Class II: 30% co-insurance*, Class III: 50% co-insurance* Adult: 100% of charges	Not covered	Some services require prior approval. Deductible does not apply to Preventive fluoride supplements for children with non-fluoridated drinking water.

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.)

- Acupuncture
- Cosmetic Surgery (except with prior approval for reconstruction)
- Dental care (age 21 and older)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (age 21 and older)
- Routine foot care (except for treatment of diabetes)
- Weight loss programs

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.)

- Abortion
- Bariatric surgery (requires prior approval)
- Chiropractic Care (requires prior approval after 12 visits)
- Non-emergency care when traveling outside the U.S. (www.bcbsvt.com/coveragewhiletraveling)
- Private-duty nursing (covered up to 14 hours per member per plan year)

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, kwiijigo holne' (800) 255-4550.

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:** $6,130
- **Patient pays :** $1,410

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	$200
Co-pays	$1,060
Coinsurance	$0
Limits or exclusions	$150
Total	$1,410

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

- **Amount owed to providers:** $5,400
- **Plan Pays:** $3,730
- **Patient pays :** $1,670

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	$200
Co-pays	$1,390
Coinsurance	$0
Limits or exclusions	$80
Total	$1,670

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.