

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

Coverage For: VEHI Plan 13 GF **Plan Type:** Indemnity



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/comp_cert or by calling (800) 255-4550. To access or request a copy of the Uniform Glossary, please visit www.bcbsvt.com/glossary or call (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall deductible ?	\$300 Individual / \$600 Two-Person/Family per plan year The plan pays benefits when an individual or the family meets the deductible. Co-insurance and co-payments do not apply to the deductible. Does not apply to prescription drugs.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. See the "Common Medical Event" chart, that appears later in this document, for how much you pay for covered services after you meet the deductible. Your plan year: January 1, 2013 through December 31, 2013 . All accumulators, such as deductibles , out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. 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?	No.	You don't have to meet deductibles for specific services, but see the "Common Medical Event" chart, that appears later in this document, for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$600 Individual / \$1,200 Two-Person/Family per plan year \$600 Individual/ \$1,200 Two-Person/Family prescription drug out-of-pocket limit per plan year	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 and health care this plan doesn't cover. Co-payments do not apply to your medical or prescription drug out-of-pocket limit.	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 "Common Medical Event" chart, that appears later in this document, describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.

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\$300/\$600 deductible, 20% co-insurance
Pharmacy: \$5 co-payment/\$20 co-payment/\$45 co-payment

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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 (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 "Common Medical Event" chart for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan. Some services require prior approval.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the "Excluded Services & Other Covered Services" section of this document. 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 participating **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
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	See also, "If you have a test" for diagnostic tests or imaging.

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		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Specialist visit	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Certain provider specialties must be participating or there is no benefit. See also, "If you have a test" for diagnostic tests or imaging. Some services require prior approval.
	Other practitioner office visit	Chiropractor: Deductible, then 20% co-insurance	Chiropractor: Not covered	Requires prior approval after 12 chiropractic visits per plan year. Nutritional counseling benefits covered up to three visits per plan year. Visits for treatment of diabetes do not count toward this visit limit.
		Nutritional counseling: Deductible, then 20% co-insurance	Nutritional counseling: Not covered	
		OB/GYN: Deductible, then 20% co-insurance	OB/GYN: Deductible, then 20% co-insurance	
	Outpatient physical, speech, and occupational therapy	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Covered up to 30 visits combined per plan year.
Preventive care/Screening/Immunization	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	See also, "If you have a test" for diagnostic tests or imaging. Preventive care benefits must meet the plan's definition of screening/preventive. For clarification on preventive services visit www.bcbsvt.com/preventive .	

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If you visit a health care provider's office or clinic	Preventive care tests	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	See also, "If you have a test" for diagnostic or imaging.
	Screening mammogram	No charge	No charge	See also, "If you have a test" for diagnostic tests or imaging.
	Colorectal screening	No charge	No charge	See also, "If you have a test" for diagnostic tests or imaging.
If you have a test	Diagnostic test (x-ray, blood work)	Office based: Deductible, then 20% co-insurance	Office based: Deductible, then 20% co-insurance	Some services require prior approval.
		Outpatient hospital: Deductible, then 20% co-insurance	Outpatient hospital: Deductible, then 20% co-insurance	
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Most services require prior approval.

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		Participating Provider	Non-Participating Provider	
<p>If you need drugs to treat your illness or condition. More information about prescription drug coverage is at www.bcbsvt.com/rxcenter.</p>	Generic drugs	<p>Retail: \$5 co-payment per 30-day supply</p> <p>Home Delivery: -\$5 co-payment per 30-day supply -\$10 co-payment per 60-day supply -\$10 co-payment per 90-day supply</p>	Not covered	<p>Some prescription drugs require prior approval.</p> <p>Prescription drug out-of-pocket limit: \$600 Individual/ \$1,200 Two-Person/Family per plan year.</p> <p>Benefits provided for up to a 90-day supply for most prescription drugs. All generic and brand diabetic prescription drugs are covered at 100%.</p>
	Preferred brand drugs	<p>Retail: \$20 co-payment per 30-day supply</p> <p>Home Delivery: -\$20 co-payment per 30-day supply -\$40 co-payment per 60-day supply -\$40 co-payment per 90-day supply</p>	Not covered	<p>Some prescription drugs require prior approval.</p> <p>Prescription drug out-of-pocket limit: \$600 Individual/ \$1,200 Two-Person/Family per plan year.</p> <p>Benefits provided for up to a 90-day supply for most prescription drugs.</p>

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If you need drugs to treat your illness or condition. More information about prescription drug coverage is at www.bcbsvt.com/rxcenter .	Non-preferred brand drugs	Retail: \$45 co-payment per 30-day supply Home Delivery: -\$45 co-payment per 30-day supply -\$90 co-payment per 60-day supply -\$90 co-payment per 90-day supply	Not covered	Some prescription drugs require prior approval. Prescription drug out-of-pocket limit: \$600 Individual/ \$1,200 Two-Person/Family per plan year. Benefits provided for up to a 90-day supply for most prescription drugs.
	Wellness drugs	Wellness drugs process the same as any other prescription. Please refer to the prescription drug benefits identified above.	Not covered	Some prescription drugs require prior approval. Benefits provided for up to a 90-day supply for most prescription drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Some services require prior approval.
	Physician/surgeon fees	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Some services require prior approval.

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		Participating Provider	Non-Participating Provider	
If you need immediate medical attention	Emergency room facility services	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Your condition must meet the criteria for an emergency medical condition . For emergency care, you may use participating or non-participating providers and obtain preferred benefits.
	Emergency room physician services	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Your condition must meet the criteria for an emergency medical condition . For emergency care, you may use participating or non-participating providers and obtain preferred benefits.
	Emergency mental health and substance use physician and facility services	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Your condition must meet the criteria for an emergency medical condition . For emergency care, you may use participating or non-participating providers and obtain preferred benefits.

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		Participating Provider	Non-Participating Provider	
If you need immediate medical attention	Emergency medical transportation	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Your condition must meet the criteria for an emergency medical condition . All non-emergency transport requires prior approval. You must get approval within 48 hours after emergency air or water transport.
	Urgent care	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	For urgent care , you may use participating or non-participating providers and obtain preferred benefits. Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Out-of-state inpatient care requires prior approval.
	Physician/surgeon fee	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Some services require prior approval.
	Mental/Behavioral health office visits	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Some services require prior approval.
	Mental/Behavioral health inpatient services	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Some services require prior approval.

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		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder office visits	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Some services require prior approval.
	Substance use disorder inpatient services	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Members enrolled in our Better Beginnings program receive extra benefits.
	Delivery and all inpatient services	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Out-of-state inpatient care requires prior approval.
If you need help recovering or have other special health needs	Home health care	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Private duty nursing and home infusion therapy require prior approval. This plan does not cover home infusion therapy with a non-participating provider .
	Rehabilitation services	Inpatient: Deductible, then 20% co-insurance Cardiac/Pulmonary: Deductible, then 20% co-insurance	Inpatient: Deductible, then 20% co-insurance Cardiac/Pulmonary: Not covered	This plan does not cover care in a non-participating physical rehabilitation facility. Requires prior approval. Cardiac rehabilitation covered up to 36 visits per cardiac event.

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		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Habilitation services	Varies based on type or place of service. Please see the applicable row in this table.	Varies based on type or place of service. Please see the applicable row in this table.	Requires prior approval. For applied behavioral analysis (ABA), see "Mental/behavioral health office visits". See also, "If you visit a health care provider's office or clinic" for outpatient physical, speech and occupational therapy.
	Skilled nursing care (facility)	Deductible, then 20% co-insurance	Not covered	Care in a skilled nursing facility requires prior approval.
	Durable medical equipment (including supplies)	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Some durable medical equipment and supplies require prior approval.
	Hospice service	Deductible, then 20% co-insurance	Deductible, then 20% co-insurance	Requires prior approval.
If you or your child needs dental or eye care	Eye exam	Not covered	Not covered	None
	Glasses	Not Covered	Not Covered	None
	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](#).)

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

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.)

- Bariatric Surgery
- Non-emergency care when traveling outside the U.S. (www.bcbsvt.com/coveragewhiletraveling)
- Chiropractic Care (requires prior approval after 12 visits)
- Private-duty nursing (covered up to \$2,000 per plan year)
- Infertility treatment

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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.

- **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, kwijigo 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:**
- **Patient pays :** *

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	*
Co-pays	*
Coinsurance	*
Limits or exclusions	*
Total	*

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

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

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	*
Co-pays	*
Coinsurance	*
Limits or exclusions	*
Total	*

*Please refer to your costs in the previous sections of this document.

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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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Template Name : BCBS-COMP-042012