

BCBSVT Catamount Summary of Benefits

1-800-255-4550

www.bcbsvt.com

Monthly Rates	Individual - \$393.11	Two Person - \$786.22	Family – \$1,100.70
	Preferred Providers		Non-Preferred Providers
Individual Calendar Year Deductible	\$250		\$500
Two-person/Family Calendar Year Deductible	\$500		\$1000
Coinsurance	20% of our Allowed Price		20% of our Allowed Price
Individual Out-of-Pocket Limit	\$800		\$1,500
Two-person/Family Out-of-Pocket Limit	\$1,600		\$3,000
Allowed Price <i>(See Definition on page 45.)</i>	We pay benefits up to our Allowed Price. Preferred Providers accept our Allowed Price as payment in full.		We pay benefits up to our Allowed Price. Non- Preferred Providers may bill you for the difference between their charges and our Allowed Price.
Transplant Benefit Limit	\$1,000,000 combined Preferred and Non-preferred Provider Benefits		
Lifetime Maximum <i>(Including prescription drug benefits)</i>	\$1,000,000 combined Preferred and Non-preferred Provider Benefits		

Office Visits	Your Costs	Plan Pays	Your Costs	Plan Pays
Preventive physical examinations <i>Includes annual OB-GYN exam, Screening mammogram, screening colonoscopy, PSA Test, well-child care and immunizations.</i>	No cost	100%	No cost	100%
Other visits with a physician	\$10 co-payment	100% after co-payment	\$10 co-payment	100% after co-payment
Sick visits to a physician	\$10 co-payment	100% after co-payment	\$10 co-payment	100% after co-payment
Mental health and substance abuse care	\$10 co-payment	100% after co-payment	100%	Not a covered benefit.
Chiropractic care <i>You must get Prior Approval for more than 12 visits in a year.</i>	\$10 co-payment	100% after co-payment	100%	Not a covered benefit.
Maternity care	Deductible and Coinsurance	80% after Deductible up to out-of-pocket limit, then 100%	Deductible and Coinsurance	80% after Deductible up to out-of-pocket limit, then 100%

Hospital Care				
Inpatient stay (semi-private room or intensive care) includes mental health and substance abuse care <i>You must get precertification. Prior approval is required for mental health And substance abuse admissions and may also be required for general hospital Services.</i>	Deductible and Coinsurance	80% after Deductible up to out-of-pocket limit, then 100%	Deductible and Coinsurance	80% after Deductible up to out-of-pocket limit, then 100%
Outpatient diagnostic Services (lab, x-ray)				
Emergency <i>Covered only if your condition is a true emergency.</i>				
Outpatient surgery				
Outpatient physical, occupational and speech therapy <i>Limited to an aggregate of 30 visits per Calendar year.</i>				

Home Care and Rehabilitation Services				
Inpatient skilled nursing or rehabilitation <i>Limited to 100 days per year.</i>	Deductible and Coinsurance	80% after Deductible up to out-of-pocket limit, then 100%	Deductible and Coinsurance	80% after Deductible up to out-of-pocket limit, then 100%
Home health and hospice care <i>Service-specific limitations outlined in subscriber certificate.</i>	Deductible and Coinsurance	80% after Deductible up to out-of-pocket limit, then 100%	Deductible and Coinsurance	80% after Deductible up to out-of-pocket limit, then 100%
Private duty nursing <i>Benefits limited to \$2,000 per calendar year.</i>	Deductible and Coinsurance	80% after Deductible up to out-of-pocket limit, then 100%	Deductible and Coinsurance	80% after Deductible up to out-of-pocket limit, then 100%

Other Services				
Ambulance	Deductible and Coinsurance	80% after Deductible up to out-of-pocket limit, then 100%	Preferred Provider Deductible and Coinsurance up to Out-of-Pocket Limit, then 100%	80% after Preferred Provider Deductible and Coinsurance up to Out-of-Pocket Limit; then 100%
Medical equipment and supplies <i>Limited to \$25,000 per year, preferred Provider and non-preferred provider benefits combined.</i>	Deductible and Coinsurance	80% after Deductible up to out-of-pocket limit, then 100%	*Subject to non-preferred deductible and coinsurance.	80% after Deductible up to out-of-pocket limit, then 100%
Prescription Drugs <i>Includes mail order.</i>	\$10 generic \$30 Preferred Brand-name \$50 Non-preferred Brand-name	100% after co-payment	100%	Not a covered benefit.

Notes:

- Non-preferred providers may balance bill you for fees above BCBSVT's allowed amount.
- \$1,000,000 lifetime benefit limit includes prescription drugs.
- BCBSVT waives Deductibles, Co-payments and Coinsurance for Preventive Care as described above and for Chronic Care Services (including but not limited to mental health and substance abuse care) if you are actively participating in one of their Chronic Care Management programs.
- For many Services, BCBSVT requires that you get Prior Approval or Precertification before obtaining care. If you do not, they may reduce your benefits. For mental health and substance abuse treatment, call 1-800-395-1356 for Prior Approval.
- BCBSVT may not notify you when you are near your benefit limits. When they determine benefits on a claim, they send you an Explanation of Benefits. You should keep a record of the benefits you use to determine when you have reached your benefit limits. You pay in full charges for Services you receive after you reach your benefit limits.

Please Read Your Contract Carefully

This Outline of Coverage provides a description of some important features of the coverage. However, the Contract sets forth in detail the rights and obligations of both you and Blue Cross and Blue Shield of Vermont. Terms used in this Summary are defined in the Contract. It is important that you read the entire Contract carefully.

Questions and Inquiries

Walk in:

Berlin (Main) Office
445 Industrial Lane
(off Airport Road)

Write:

Customer Service
Department
Blue Cross and Blue
Shield of Vermont
P.O. Box 186
Montpelier, VT
05601-0186

Call:

7 a.m. to 6 p.m.
(888) 445-5805

Web Site:

www.bcbsvt.com