Benefit Information

Benefit Description	Copay	Coinsurance	Deductible Individual	Deductible Family	Benefit Limit	Dollar Limit	Out of Pocket Max Individual	Out of Pocket Max Family
Office Visits		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Preventive Office Visits		100% Coverage	No Deductible Applies	No Deductible Applies	No Visit Limit	No Dollar Limit	No Out of Pocket Maximum Applies	No Out of Pocket Maximum Applies
Ambulance Services		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Chiropractic Services (Prior approval required after 12th visit)		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Colorectal Screening (Facility Only)		100% Coverage	No Deductible Applies	No Deductible Applies	No Visit Limit	No Dollar Limit	No Out of Pocket Maximum Applies	No Out of Pocket Maximum Applies
Colorectal Screening		100% Coverage	No Deductible Applies	No Deductible Applies	No Visit Limit	No Dollar Limit	No Out of Pocket Maximum Applies	No Out of Pocket Maximum Applies
Dental Services *Refer to Contract Documents for Limitations		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Diagnostic Services (Labs/X-rays)		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Durable Medical Equipment		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Emergency Room Physician		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Home Health Visits		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Hospice Care		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Inpatient Hospital		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Inpatient Hospital - Bariatric Facility Services		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	$ 10000 Max Benefit (Life)	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Inpatient Skilled Nursing		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Maternity Professional Services		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Maternity Inpatient Hospital Services		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Mental Health / Substance Abuse - Emergency Room Facility		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Mental Health / Substance Abuse - Emergency Room Physician		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Mental Health / Substance Abuse - Inpatient		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Mental Health / Substance Abuse - Outpatient		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Applied Behavioral Analysis (up to and including 21 years of age)		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Nutritional Counseling (Benefit Limit does not apply to diabetics)		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	3 Maximum Visits (Plan Year)	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Outpatient Hospital (Surgical)		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Outpatient Hospital (Other Facility Services)		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Physical, Occupational and Speech Therapy (Physician Services)		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	30 Maximum Visits (Plan Year)	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Private Duty Nursing		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	$ 2000 Max Benefit (Plan Yr)	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Rehabilitative Services Inpatient Hospital		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Rehabilitative Services (Cardiac Rehab)		10 % Coinsurance	$ 2450 Individual Deductible (Plan Year)	$ 4900 Two-Person/Family Deductible (Plan Yr)	No Visit Limit	No Dollar Limit	$ 5950 Individual Out of Pocket (Plan Year)	$ 11900 Two-Person/Family Out of Pocket (Plan Yr)
Screening Mammograms		100% Coverage	No Deductible Applies	No Deductible Applies	No Visit Limit	No Dollar Limit	No Out of Pocket Maximum Applies	No Out of Pocket Maximum Applies

Benefit Plan Information

Carrier	Blue Cross Blue Shield	Start Date	[illegible]
Product	Indemnity [Comprehensive]	End Date	
Group	[illegible] (CHAMBER BENEFI [illegible]	Relationship	Self
Division Number	[illegible]		
Group Benefit Effective	January		
Benefits Document(s)	Health Plan Contract		

Additional Information

No COB information is available.

Your accumulations reset on your group benefit effective month. To learn more about this Click here.

Start Date:
The start date is the most recent date that your current group or non-group policy renewed with Blue Cross and Blue Shield of VT with changes or updates to your benefits. If your effective date and start date are the same then no changes have been made to your policy.

COB Definition:
If you have primary medical insurance with another carrier, that carrier's name will display under Additional Information. If you do not have other medical insurance, the "No COB (Coordination of Benefits) Information" message will display.

Other Insurance:
Do you need to update your Other Insurance information? If yes, please click here to send a secure message to the Customer Service Department.