VERMONT LEGAL AID, INC.

OFFICE OF THE HEALTH CARE ADVOCATE

264 NORTH WINOOSKI AVE.
BURLINGTON, VERMONT 05401
(800) 917-7787 (TOLL FREE HOTLINE)
(802) 863-7152 (FAX)

OFFICES:
BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:
MONTPELIER
SPRINGFIELD

July 23, 2018

Green Mountain Care Board
3rd Floor City Center
89 Main Street
Montpelier, VT 05620

Re: Stipulated Administrative Notice Items – Blue Cross and Blue Shield of Vermont - Vermont Health Connect 2019 Filing (GMCB 009-18r)

Dear Ms. Kessler

As agreed to at the July 23, 2018, hearing and upon the request of the counsel of Blue Cross Blue Shield of Vermont, I am attaching to this email the .pdf files of items that the HCA moves the Green Mountain Care Board (Board) take administrative notice of. As stated in the letter dated July 22, 2018, the parties to this action have stipulated that the Board may take administrative notice of these items. Also as stated in the letter dated July 22, 2018, the HCA moves that the Board take administrative notice of the below listed items.

- 2018 Federal Poverty guidelines;
  - Attached as 2017_FederalPovertyGuidelines.pdf
- 2017 Federal Poverty guidelines;
  - Attached as 2017_FederalPovertyGuidelines.pdf
- Patient Protection and Affordable Care Act 2018 Premium Affordability Threshold;
  - Attached as 2018_ACAPremiumAffordabilityThresholds.pdf
- Vermont Gross Domestic Product Data from 2012 through the end of 2017, U.S. Bureau of Labor Statistics;
  - Attached as VtGrossDomesticProduct_2012through2017.pdf
- U.I Covered Employment and Wages (QCEW): Annual & Quarterly Averages, Vermont Department of Labor;
  - The U.I Covered Employment and Wages (QCEW): Annual & Quarterly Averages released by the Vermont Department of Labor. This data is available at http://www.vtlmi.info/indnaics.htm (last accessed on 7.20.2018).
- Consumer Price Index for All Urban Consumers: All items in Northeast [CUUR0100SA0], U.S. Bureau of Labor Statistics;
  - Attached as BLS_CPI_NortheastRegion.pdf
- 2018 VHC Plan Designs & Monthly Premiums (before subsidy), Vermont Health Connect;
  - Attached as 2018_VHCPlanDesignsAndMonthlyPremiums.pdf
- 2018 Silver Plan Designs with Cost-Sharing Reductions, Vermont Health Connect;
  - Attached as 2018_VHCSilverPlanDesignsWithCostSharing.pdf

- 2018 VHC Silver 94 Plan Design, Vermont Health Connect;
    - Attached as 2018_VHCSilver94Plans.pdf
- 2018 VHC Silver 87 Plans, Vermont Health Connect;
    - Attached as 2018_VHCSilver87Plans.pdf
- 2018 VHC Silver 77 Plan Design, Vermont Health Connect;
    - Attached as 2018_VHCSilver77Plans.pdf
- 2018 VHC Silver 73 Plan Design, Vermont Health Connect;
    - Attached as 2018_VHCSilver73Plans.pdf
- 2018 Vermont Medicaid and Dr. Dynasaur Eligibility Guidelines, Vermont Health Connect.
    - Attached as 2018_VHC_MedicaidAndDrDynasaur_EligibilityGuidlines.pdf

s/ Eric Schultheis
Eric Schultheis, Ph.D.
Staff Attorney
Office of the Health Care Advocate

Authority: Federal Advisory Committee Act, Pub. L. 92–463.

Dated: January 18, 2017.

Wendy M. Payne,

Executive Director.

[FR Doc. 2017–02028 Filed 1–30–17; 8:45 am]

BILLING CODE 1610–01–P

FEDERAL ELECTION COMMISSION

Sunshine Act Meetings

AGENCY: Federal Election Commission.

DATE AND TIME: Wednesday, February 1, 2017 at 10:00 a.m.

PLACE: 999 E Street NW., Washington, DC (Ninth Floor).

STATUS: This meeting will be open to the public.

FEDERAL REGISTER NOTICE OF PREVIOUS ANNOUNCEMENT: 82 FR 8613.

CHANGE IN THE MEETING: The February 1, 2017 Public Hearing on Internet Communication Disclaimers has been postponed.

PERSON TO CONTACT FOR INFORMATION: Judith Ingram, Press Officer, Telephone: (202) 694–1220.

Dayna C. Brown,

Acting Secretary and Clerk of the Commission.

[FR Doc. 2017–02090 Filed 1–27–17; 11:15 am]

BILLING CODE 6715–01–P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The applications will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than February 24, 2017.

A. Federal Reserve Bank of Chicago (Colette A. Fried, Assistant Vice President) 230 South LaSalle Street, Chicago, Illinois 60690–1414:

1. *Nicolet Bankshares, Inc.,* Green Bay, Wisconsin; to acquire 100 percent of First Menasha Bancshares, Inc., Neenah, Wisconsin, and thereby indirectly acquire The First National Bank—Fox Valley, Neenah, Wisconsin.

B. Federal Reserve Bank of Minneapolis (Jacquelyn K. Brunmeier, Assistant Vice President) 90 Hennepin Avenue, Minneapolis, Minnesota 55480–0291:

1. *Ameri Financial Group, Inc.,* Stillwater, Minnesota; to acquire 100 percent of First Resource Bank, Lino Lakes, Minnesota.

C. Federal Reserve Bank of San Francisco (Gerald C. Tsai, Director, Applications and Enforcement) 101 Market Street, San Francisco, California 94105–1579:

1. *BayCom Corp,* Walnut Creek, California; to merge with First ULB Corp., and thereby indirectly acquire United Business Bank, F.S.B., both of Oakland, California; and thereby engage in operating a savings association pursuant to 225.28(b)(4).

Board of Governors of the Federal Reserve System, January 25, 2017.

Yao-Chin Chao,

Assistant Secretary of the Board.

[FR Doc. 2017–01985 Filed 1–30–17; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This notice provides an update of the Department of Health and Human Services (HHS) poverty guidelines to account for last calendar year's increase in prices as measured by the Consumer Price Index.

DATES: *Effective Date:* January 26, 2017 unless an office administering a program using the guidelines specifies a different effective date for that particular program.

ADDRESSES: Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: For information about how the guidelines are used or how income is defined in a particular program, contact the Federal, state, or local office that is responsible for that program. For information about poverty figures for immigration forms, the Hill-Burton Uncompensated Services Program, and the number of people in poverty, use the specific telephone numbers and addresses given below.

For general questions about the poverty guidelines themselves, contact Suzanne Macartney, Office of the Assistant Secretary for Planning and Evaluation, Room 422F.3, Humphrey Building, Department of Health and Human Services, Washington, DC 20201—telephone: (202) 690–6143—or visit *http://aspe.hhs.gov/poverty/*.

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I–864, Affidavit of Support, contact U.S. Citizenship and Immigration Services at 1–800–375–5283.

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Health Resources and Services Administration Information Center at 1–800–275–4772. You also may visit *http://www.hrsa.gov/gethealthcare/affordable/hillburton/*.

For information about the number of people in poverty, visit the Poverty section of the Census Bureau's Web site at *http://www.census.gov/hhes/www/poverty/poverty.html* or contact the Census Bureau's Customer Service Center at 1–800–923–8282 (toll-free) or visit *https://ask.census.gov* for further information.

SUPPLEMENTARY INFORMATION:

Background

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update the poverty guidelines at least annually, adjusting them on the basis of the Consumer Price

Index for All Urban Consumers (CPI–U). The poverty guidelines are used as an eligibility criterion by the Community Services Block Grant program and a number of other Federal programs. The *poverty guidelines* issued here are a simplified version of the *poverty thresholds* that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI–U). The guidelines in this 2017 notice reflect the 1.3 percent price increase between calendar years 2015 and 2016. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. In rare circumstances, the rounding and standardizing adjustments in the formula result in small decreases in the poverty guidelines for some household sizes even when the inflation factor is not negative. In cases where the year-to-year change in inflation is not negative and the rounding and standardizing adjustments in the formula result in reductions to the guidelines from the previous year for some household sizes, the guidelines for the affected household sizes are fixed at the prior year's guidelines. As in prior years, these 2017 guidelines are roughly equal to the poverty thresholds for calendar year 2016 which the Census Bureau expects to publish in final form in September 2017.

The poverty guidelines continue to be derived from the Census Bureau's current official poverty thresholds; they are not derived from the Census Bureau's Supplemental Poverty Measure (SPM).

The following guideline figures represent annual income.

2017 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household	Poverty guideline
1	$12,060
2	16,240
3	20,420
4	24,600
5	28,780
6	32,960
7	37,140
8	41,320

For families/households with more than 8 persons add $4,180 for each additional person.

2017 POVERTY GUIDELINES FOR ALASKA

Persons in family/household	Poverty guideline
1	$15,060
2	20,290
3	25,520
4	30,750
5	35,980
6	41,210
7	46,440
8	51,670

For families/households with more than 8 persons, add $5,230 for each additional person.

2017 POVERTY GUIDELINES FOR HAWAII

Persons in family/household	Poverty guideline
1	$13,860
2	18,670
3	23,480
4	28,290
5	33,100
6	37,910
7	42,720
8	47,530

For families/households with more than 8 persons, add $4,810 for each additional person.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period. (Note that the Census Bureau poverty thresholds—the version of the poverty measure used for statistical purposes—have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

Due to confusing legislative language dating back to 1972, the poverty guidelines sometimes have been mistakenly referred to as the ''OMB'' (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty guidelines may be formally referenced as ''the poverty guidelines updated periodically in the **Federal Register** by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).''

Some federal programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non-Federal organizations that use the poverty guidelines under their own authority in non-Federally-funded activities also may choose to use a percentage multiple of the guidelines.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

Note that this notice does not provide definitions of such terms as ''income'' or ''family,'' because there is considerable variation in defining these terms among the different programs that use the guidelines. These variations are traceable to the different laws and regulations that govern the various programs. This means that questions such as ''Is income counted before or after taxes?'', ''Should a particular type of income be counted?'', and ''Should a particular person be counted as a member of the family/household?'' are actually questions about how a specific program applies the poverty guidelines. All such questions about how a specific program applies the guidelines should be directed to the entity that administers or funds the program, since that entity has the responsibility for defining such terms as ''income'' or ''family,'' to the extent that these terms are not already defined for the program in legislation or regulations.

Dated: January 26, 2017.

Norris Cochran,

Acting Secretary of Health and Human Services.

[FR Doc. 2017–02076 Filed 1–27–17; 11:15 am]

BILLING CODE 4150–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and

Rev. Proc. 2017-36

SECTION 1. PURPOSE

This revenue procedure provides indexing adjustments for certain provisions under sections 36B and 5000A of the Internal Revenue Code. In particular, it updates the Applicable Percentage Table in § 36B(b)(3)(A)(i) to provide the Applicable Percentage Table for 2018. This table is used to calculate an individual's premium tax credit. This revenue procedure also updates the required contribution percentage in § 36B(c)(2)(C)(i)(II) for plan years beginning after calendar year 2017. The percentage is used to determine whether an individual is eligible for affordable employer-sponsored minimum essential coverage under § 36B. This revenue procedure uses the methodology described in Section 4 of Rev. Proc. 2014-37, 2014-2 C.B. 363, to index the Applicable Percentage Table and the § 36B required contribution percentage for 2018. Additionally, this revenue procedure cross-references the required contribution percentage under § 5000A(e)(1)(A) for plan years beginning after calendar year 2017, as determined under guidance issued by the Department of Health and Human Services. The percentage is used to determine whether an individual is eligible for an exemption from the individual shared responsibility payment because of a lack of affordable minimum essential coverage.

SECTION 2. ADJUSTED ITEMS

.01 *Applicable Percentage Table for 2018*. For taxable years beginning in 2018, the Applicable Percentage Table for purposes of § 36B(b)(3)(A)(i) and § 1.36B-3T(g) is:

Household income percentage of Federal poverty line:	Initial percentage	Final percentage
Less than 133%	2.01%	2.01%
At least 133% but less than 150%	3.02%	4.03%
At least 150% but less than 200%	4.03%	6.34%
At least 200% but less than 250%	6.34%	8.10%
At least 250% but less than 300%	8.10%	9.56%
At least 300% but not more than 400%	9.56%	9.56%

.02 *Section 36B Required Contribution Percentage for 2018*. For plan years beginning in 2018, the required contribution percentage for purposes of § 36B(c)(2)(C)(i)(II) and § 1.36B-2T(c)(3)(v)(C) is 9.56%.

.03 *Section 5000A Required Contribution Percentage*. In the 2018 Benefit and Payment Parameters, 81 Fed. Reg. 94058 (December 22, 2016), for plan years beginning in 2018, the Department of Health and Human Services (HHS) announced that the Section 5000A required contribution percentage for purposes of § 5000A(e)(1)(A) and § 1.5000A-3(e)(2) is 8.05%. See Exchange and Insurance Market Standards for 2015 and beyond, 79 Fed. Reg. 30239, 30302 (May 27, 2014), for further information on the computation methodology and publication approach for the Section 5000A required contribution percentage.

SECTION 3. EFFECTIVE DATE

This revenue procedure is effective for taxable years and plan years beginning after December 31, 2017.

SECTION 4. DRAFTING INFORMATION

The principal author of this revenue procedure is Bill Ruane of the Office of Associate Chief Counsel (Income Tax and Accounting). For further information regarding this revenue procedure, contact Mr. Bill Ruane at (202) 317-4718 (not a toll-free call).

• *Confidential Submissions*—To submit an application with confidential information that you do not wish to be made publicly available, submit your application only as a written/paper submission. You should submit two copies total. One copy will include the information you claim to be confidential with a heading or cover note that states ''THIS DOCUMENT CONTAINS CONFIDENTIAL INFORMATION.'' The Agency will review this copy, including the claimed confidential information, in its consideration of your application. The second copy, which will have the claimed confidential information redacted/blacked out, will be available for public viewing and posted on *https://www.regulations.gov.* Submit both copies to the Dockets Management Staff. If you do not wish your name and contact information to be made publicly available, you can provide this information on the cover sheet and not in the body of your application and you must identify this information as ''confidential.'' Any information marked as ''confidential'' will not be disclosed except in accordance with 21 CFR 10.20 and other applicable disclosure law. For more information about FDA's posting of comments to public dockets, see 80 FR 56469, September 18, 2015, or access the information at: *https://www.gpo.gov/fdsys/pkg/FR-2015-09-18/pdf/2015-23389.pdf.*

Docket: For access to the docket, go to *https://www.regulations.gov* and insert the docket number, found in brackets in the heading of this document, into the ''Search'' box and follow the prompts and/or go to the Dockets Management Staff, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852 between 9 a.m. and 4 p.m., Monday through Friday. Publicly available submissions may be seen in the docket.

FOR FURTHER INFORMATION CONTACT: Julie Finegan, Office of Scientific Integrity, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 1, Rm. 4218, Silver Spring, MD 20993, 301–796–8618.

SUPPLEMENTARY INFORMATION:

I. Background

On June 24, 2013, the U. S. District Court for the Eastern District of Tennessee entered a criminal judgment against William Ralph Kincaid pursuant to his guilty plea. Kincaid pled guilty to a felony under the FD&C Act, namely receiving in interstate commerce a misbranded drug with intent to defraud or mislead, in violation of sections 301(c) and 303(a)(2) of the FD&C Act (21 U.S.C. 331(c) and 333(a)(2)) and 18 U.S.C. 2. The basis for this conviction was Kincaid's admission that he obtained drugs from Quality Specialty Products (QSP), a foreign company, for use at East Tennessee Hematology-Oncology Associates, P.C. (McLeod Cancer). These drugs were not FDA approved and were misbranded in that they lacked adequate directions for use and were manufactured in an establishment that was not registered with FDA and that did not list with FDA the drug products it manufactured. From approximately September 2007 to early 2008 and from August 2009 to February 2012, McLeod Cancer purchased more than $2 million in misbranded unapproved drugs for use at McLeod Cancer. Additionally, Kincaid and McLeod Cancer billed Medicare, TennCare, and other government health benefit programs approximately $2.5 million for these unapproved drugs.

Kincaid is subject to debarment based on a finding, under section 306(a)(2) of the FD&C Act (21 U.S.C. 335a(a)(2)), that he was convicted of a felony under Federal law for conduct relating to the regulation of a drug product under the FD&C Act. By the letter dated May 20, 2015, FDA notified Kincaid of a proposal to permanently debar him from providing services in any capacity to a person having an approved or pending drug product application. The proposal also offered Kincaid an opportunity to request a hearing, providing him 30 days from the date of receipt of the letter in which to file the request and 60 days from the date of receipt of the letter to support that request with information sufficient to justify a hearing. In a letter dated June 17, 2015, Kincaid requested a hearing and indicated that the information justifying the hearing would be forthcoming. More than 60 days have passed from the date Kincaid received FDA's letter, and Kincaid has not filed any additional information to support his request.

Under the authority delegated to him by the Commissioner of Food and Drugs, the Director of the Office of Scientific Integrity (OSI) has considered Kincaid's request for a hearing. Hearings will not be granted on issues of policy or law, on mere allegations, denials, or general descriptions of positions and contentions, or on data and information insufficient to justify the factual determination urged (see 21 CFR 21.24(b)).

Because Kincaid has not presented any information to support his hearing request, OSI concludes that Kincaid failed to raise a genuine and substantial issue of fact requiring a hearing. Therefore, OSI denies Kincaid's request for a hearing.

II. Findings and Order

Therefore, OSI, under section 306(a)(2) of the FD&C Act and under the authority delegated, finds that William Ralph Kincaid has been convicted of a felony under Federal law for conduct relating to the regulation of a drug product under the FD&C Act.

As a result of the foregoing findings, William Ralph Kincaid is permanently debarred from providing services in any capacity to a person with an approved or pending drug product application under section 505, 512, or 802 of the FD&C Act (21 U.S.C. 355, 360b, or 382), or under section 351 of the Public Health Service Act (42 U.S.C. 262), effective (see **DATES**) (21 U.S.C. 335a(c)(1)(B) and (c)(2)(A)(ii) and 21 U.S.C. 321(dd)). Any person with an approved or pending drug product application who knowingly uses the services of Kincaid, in any capacity during his period of debarment, will be subject to civil money penalties. See section 307(a)(6) of the FD&C Act (21 U.S.C. 335b(a)(6)). If Kincaid, during his period of debarment, provides services in any capacity to a person with an approved or pending drug product application, he will be subject to civil money penalties. See section 307(a)(7) of the FD&C Act (21 U.S.C. 335b(a)(7)). In addition, FDA will not accept or review any abbreviated new drug applications submitted by or with the assistance of Kincaid during his period of debarment.

Dated: January 10, 2018.

G. Matthew Warren,

Director, Office of Scientific Integrity.

[FR Doc. 2018–00719 Filed 1–17–18; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This notice provides an update of the Department of Health and Human Services (HHS) poverty guidelines to account for last calendar year's increase in prices as measured by the Consumer Price Index.

DATES: Applicable beginning January 13, 2018, unless an office administering a program using the guidelines specifies a different applicability date for that particular program.

ADDRESSES: Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: For information about how the guidelines are used or how income is defined in a particular program, contact the Federal, state, or local office that is responsible for that program. For information about poverty figures for immigration forms, the Hill-Burton Uncompensated Services Program, and the number of people in poverty, use the specific telephone numbers and addresses given below.

For general questions about the poverty guidelines themselves, contact Kendall Swenson, Office of the Assistant Secretary for Planning and Evaluation, Room 422F.5, Humphrey Building, Department of Health and Human Services, Washington, DC 20201—telephone: (202) 690–7409—or visit *http://aspe.hhs.gov/poverty/.*

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I–864, Affidavit of Support, contact U.S. Citizenship and Immigration Services at 1–800–375–5283.

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Health Resources and Services Administration Information Center at 1–800–275–4772. You also may visit *https://www.hrsa.gov/get-health-care/affordable/hill-burton/index.html.*

For information about the number of people in poverty, visit the Poverty section of the Census Bureau's website at *https://www.census.gov/topics/income-poverty/poverty.html* or contact the Census Bureau's Customer Service Center at 1–800–923–8282 (toll-free) or visit *https://ask.census.gov* for further information.

SUPPLEMENTARY INFORMATION:

Background

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update the poverty guidelines at least annually, adjusting them on the basis of the Consumer Price Index for All Urban Consumers (CPI–U). The poverty guidelines are used as an eligibility criterion by Medicaid and a number of other Federal programs. The *poverty guidelines* issued here are a simplified version of the *poverty thresholds* that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI–U). The guidelines in this 2018 notice reflect the 2.1 percent price increase between calendar years 2016 and 2017. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. In rare circumstances, the rounding and standardizing adjustments in the formula result in small decreases in the poverty guidelines for some household sizes even when the inflation factor is not negative. In cases where the year-to-year change in inflation is not negative and the rounding and standardizing adjustments in the formula result in reductions to the guidelines from the previous year for some household sizes, the guidelines for the affected household sizes are fixed at the prior year's guidelines. As in prior years, these 2018 guidelines are roughly equal to the poverty thresholds for calendar year 2017 which the Census Bureau expects to publish in final form in September 2018.

The poverty guidelines continue to be derived from the Census Bureau's current official poverty thresholds; they are not derived from the Census Bureau's Supplemental Poverty Measure (SPM).

The following guideline figures represent annual income.

2018 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty guideline
1	$12,140
2	16,460
3	20,780
4	25,100
5	29,420
6	33,740
7	38,060
8	42,380

For families/households with more than 8 persons, add $4,320 for each additional person.

2018 Poverty Guidelines for Alaska

Persons in family/household	Poverty guideline
1	$15,180
2	20,580
3	25,980
4	31,380
5	36,780
6	42,180
7	47,580
8	52,980

For families/households with more than 8 persons, add $5,400 for each additional person.

2018 Poverty Guidelines for Hawaii

Persons in family/household	Poverty guideline
1	$13,960
2	18,930
3	23,900
4	28,870
5	33,840
6	38,810
7	43,780
8	48,750

For families/households with more than 8 persons, add $4,970 for each additional person.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period. (Note that the Census Bureau poverty thresholds—the version of the poverty measure used for statistical purposes—have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

Due to confusing legislative language dating back to 1972, the poverty guidelines sometimes have been mistakenly referred to as the ''OMB'' (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty guidelines may be formally referenced as ''the poverty guidelines updated periodically in the **Federal Register** by

the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).''

Some federal programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non-Federal organizations that use the poverty guidelines under their own authority in non-Federally-funded activities also may choose to use a percentage multiple of the guidelines.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

Note that this notice does not provide definitions of such terms as ''income'' or ''family,'' because there is considerable variation in defining these terms among the different programs that use the guidelines. These variations are traceable to the different laws and regulations that govern the various programs. This means that questions such as ''Is income counted before or after taxes?'', ''Should a particular type of income be counted?'', and ''Should a particular person be counted as a member of the family/household?'' are actually questions about how a specific program applies the poverty guidelines. All such questions about how a specific program applies the guidelines should be directed to the entity that administers or funds the program, since that entity has the responsibility for defining such terms as ''income'' or ''family,'' to the extent that these terms are not already defined for the program in legislation or regulations.

Dated: January 12, 2018.

Eric D. Hargan,

Acting Secretary of Health and Human Services.

[FR Doc. 2018–00814 Filed 1–12–18; 4:15 pm]

BILLING CODE 4150–05–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Customs and Border Protection

Automated Commercial Environment (ACE) Becoming the Sole CBP-Authorized Electronic Data Interchange (EDI) System for Processing Electronic Drawback Filings

AGENCY: U.S. Customs and Border Protection, Department of Homeland Security.

ACTION: General notice.

SUMMARY: This document announces that the Automated Commercial Environment (ACE) will be the sole electronic data interchange (EDI) system authorized by U.S. Customs and Border Protection (CBP) for processing electronic drawback filings under part 181 (NAFTA drawback) and part 191 (non-TFTEA drawback) of Title 19 of the Code of Federal Regulations. This document also announces that the Automated Commercial System (ACS) will no longer be a CBP-authorized EDI system for purposes of processing such filings. This notice further announces the deployment of a new ACE filing code for all electronic drawback filings, replacing the six distinct drawback codes previously filed in ACS.

DATES: As of February 24, 2018, ACE will be the sole CBP-authorized EDI system for processing drawback filings under part 181 (NAFTA drawback) and part 191 (non-TFTEA drawback) of Title 19 of the Code of Federal Regulations, and ACS will no longer be a CBP-authorized EDI system for such purpose.

FOR FURTHER INFORMATION CONTACT: Randy Mitchell, Commercial Operations and Entry Division, Trade Policy and Programs, Office of Trade at (202) 863–6532 or *RANDY.MITCHELL@CBP.DHS.GOV.*

SUPPLEMENTARY INFORMATION:

I. Background

Section 484 of the Tariff Act of 1930, as amended (19 U.S.C. 1484), establishes the requirement for importers of record to make entry for merchandise to be imported into the customs territory of the United States. Customs entry information is used by U.S. Customs and Border Protection (CBP) and Partner Government Agencies (PGAs) to determine whether merchandise may be released from CBP custody. Importers of record are also obligated to complete the entry by filing an entry summary declaring the value, classification, rate of duty applicable to the merchandise and such other information as is necessary for CBP to properly assess duties, collect accurate statistics and determine whether any other applicable requirement of law is met.

The customs entry requirements were amended by Title VI of the North American Free Trade Agreement Implementation Act (Pub. L. 103–182, 107 Stat. 2057, December 8, 1993), commonly known as the Customs Modernization Act, or Mod Act. In particular, section 637 of the Mod Act amended section 484(a)(1)(A) of the Tariff Act of 1930 (19 U.S.C. 1484(a)(1)(A)) by revising the requirement to make and complete customs entry by submitting documentation to CBP to allow, in the alternative, the electronic transmission of such entry information pursuant to a CBP-authorized electronic data interchange (EDI) system. CBP created the Automated Commercial System (ACS) to track, control, and process all commercial goods imported into the United States. CBP established the specific requirements and procedures for the electronic filing of entry and entry summary data for imported merchandise through the Automated Broker Interface (ABI) to ACS.

II. Transition Into the Automated Commercial Environment

In an effort to modernize the business processes essential to securing U.S. borders, facilitating the flow of legitimate shipments, and targeting illicit goods pursuant to the Mod Act and the Security and Accountability for Every (SAFE) Port Act of 2006 (Pub. L. 109–347, 120 Stat. 1884), CBP developed the Automated Commercial Environment (ACE) to eventually replace ACS as the CBP-authorized EDI system. Over the last several years, CBP has tested ACE and provided significant public outreach to ensure that the trade community is fully aware of the transition from ACS to ACE.

On October 13, 2015, CBP published an Interim Final Rule in the **Federal Register** (80 FR 61278) that designated ACE as a CBP-authorized EDI system. The designation of ACE as a CBP-authorized EDI system was effective November 1, 2015. In the Interim Final Rule, CBP stated that ACS would be phased out and anticipated that ACS would no longer be supported for entry and entry summary filing. Filers were encouraged to adjust their business practices so that they would be prepared when ACS was decommissioned.

CBP developed a staggered transition strategy for decommissioning ACS. The phases of the transition were announced in several **Federal Register** notices. *See* 81 FR 10264 (February 29, 2016); 81 FR 30320 (May 16, 2016); 81 FR 32339 (May 23, 2016); 82 FR 38924 (August 16, 2017); and 82 FR 51852 (November 8, 2017). This notice announces another transition as the processing of electronic drawback filings under parts 181 and 191 of title 19 of the Code of Federal Regulations (CFR) is transitioning into ACE.

VERMONT HEALTH CONNECT
Find the plan that's right for you.

Help Center

Vermont Health Connect

VERMONT.gov
official state website

Search

Medicaid & Dr. Dynasaur

Offered by the State of Vermont's Green Mountain Care program, Medicaid and Dr. Dynasaur are part of a family of low-cost and free health coverage programs for Vermonters. For Medicaid for Children & Adults (MCA), you can apply online (http://info.healthconnect.vermont.gov/IF/checklist) or by phone through Vermont Health Connect. Eligibility for MCA is based on family size and household income -- additional resources are not considered. For Medicaid for the Aged, Blind, and Disabled (MABD), you can apply through a paper application (http://www.greenmountaincare.org/apply-online-health-insurance) that is available online. Eligibility for MABD does consider other resources in addition to income.

- **Medicaid for Children & Adults (MCA) -** read below
- **Medicaid for the Aged, Blind, and Disabled (MABD)** - Are you 65 or older, blind, or disabled? (http://www.greenmountaincare.org/mabd)
- **Prescription Assistance -** Do you need help paying for prescriptions? (http://www.greenmountaincare.org/perscription)

Medicaid for Children & Adults (MCA)

Medicaid

Free health coverage for individuals:

- Is age 19 or older and under age 65
- Is not entitled to or enrolled in Medicare Part A and/or enrolled in Part B
- Has household income that is at or below 133% Federal Poverty Level (FPL)
- Who has a dependent child under the age of 18 or 18 and a fulltime high school student and expects to complete school before reaching age 19
- Already have Medicaid? Call Vermont Health Connect toll free at 1-855-899-9600.
- Don't have an account with Vermont Health Connect? Sign up today. (https://identity.id.vermont.gov/oaam_server/oamLoginPage.jsp?tap_token=v2.1%7EOAAMTAPPartner%7ENEUwRTFFREE2RkZFQjNCMDM4RkJCRn4wQjQ0NzQ1MjRCRUU1QTYxQ0Y0MTc2RDkzODVBMkZDNDMyNjNCQkY3fjkxRTYxODVDF%3D%3D)

Dr. Dynasaur

Low-cost or free health coverage for:

- Children under the age of 19
- Pregnant women with income below 208% FPL
- Has household income below 312% FPL
- Dr. Dynasaur is free for pregnant woman with qualifying household incomes.

- Depending on household income and family size, Dr. Dynasaur for children under 19 may have a monthly premium (see chart below).
- View the Health Care Programs Handbook (http://www.greenmountaincare.org/sites/gmc/files/ctools/2016%20VT_HlthcareProgramsHandbook_FINAL.pdf) for information on co-pays and other information, or see the Green Mountain Care

(http://www.greenmountaincare.org/) site for other resources (http://info.healthconnect.vermont.gov/tax_credit_calculator) including physician comparison tools.

- Already have Dr. Dynasaur? Call Vermont Health Connect toll free at 1-855-899-9600.
- Don't have an account with Vermont Health Connect? Sign up today. (https://identity.id.vermont.gov/oaam_server/oamLoginPage.jsp?tap_token=v2.1%7EOAAMTAPPartner%7ENEUwRTFFREE2RkZFQjNCMDM4RkJCRn4wQjQ0NzQ1MjRCRUU1QTYxQ0Y0MTc2RDkzODVBMkZDNDMyNjNCQkY3fjkxRTYxODVDF%3D%3D)

2018 Monthly Premium Income Levels for Children Who Qualify for Dr. Dynasaur with:			
Household Size*	$0 Premium	$15 premium per family per month	$20 premium per family, per month if child(ren) have other insurance. $60 per familiy, per month if child(ren) are uninsured
1	$1,973.00	$2,398.00	$3,157.00
2	$2,675.00	$3,251.00	$4,280.00
3	$3,377.00	$4,105.00	$5,403.00
4	$4,079.00	$4,958.00	$6,526.00
5	$4,781.00	$5,811.00	$7,650.00
6	$5,483.00	$6,664.00	$8,773.00
7	$6,185.00	$7,517.00	$9,896.00
8	$6,887.00	$8,371.00	$11,019.00

All Vermont Health Connect plans cover the same set of Essential Health Benefits. The difference lies in the plan designs, which determine how you pay for those benefits. Standard plans have the same designs across insurance carriers, while Blue Rewards and VT Plus plans were uniquely designed by the carriers, with a focus on wellness.

Vermont Health Connect
2018 Plan Designs & Monthly Premiums (before subsidy)

Interested in the cost *after* subsidy?
Most Vermonters who use Vermont Health Connect qualify for financial help to reduce their costs. To see if you qualify, visit the Plan Comparison Tool at https://vt.checkbookhealth.org or call 1-855-899-9600.

VERMONT HEALTH CONNECT
Find the plan that's right for you.

		Standard Plans					Standard High Deductible Health Plans (HDHP)				Blue Rewards					MVP VT Plus Non-Standard				
		BCBSVT & MVP					Can Pair with Health Savings Account (HSA)				BCBSVT only					MVP only				
		Platinum	Gold	Silver	Bronze	Bronze without Rx MOOP (New in 2018)	Silver HDHP		Bronze HDHP		Gold	Silver	Bronze without Rx MOOP (New in 2018)	Gold CDHP (HDHP) Can pair with HSA	Bronze CDHP (HDHP) without Rx MOOP (Can pair with HSA)	Gold	Silver	Bronze	Gold HDHP Can pair with HSA	Bronze without Rx MOOP (New in 2018)
							BCBSVT	MVP	BCBSVT	MVP										
		Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family
Deductible (Ded.)	Integrated Ded.?	N	N	N	N	Y - $7,350/$14,700	Y - $1,550/$3,100[7]	Y - $1,550/$3,100[7]	Y - $5,250/$10,500	Y - $5,250/$10,500	Y - $1,500/$3,000	Y - $2,750/$5,500[7]	Y - $7,350/$14,700	Y - $2,750/$5,500	Y - $6,650/$13,300	N	N	N	Y - $2,400/$4,800	Y - $7,350/$14,700
	Medical Ded.	$300/$600	$850/$1,700	$2,600/$5,200[7]	$5,000/$10,000	See above	See above	See above	See above	See above	See above	See above	See above	See above	See above	$950/$1,900	$2,000/$4,000[7]	$6,000/$12,000	See above	See above
	Waived[1] for: (see Services below)	Prev, OV, UC, Amb, Den1[11]	Prev, OV, UC, Amb, Den1[11]	Prev, OV, UC, Amb, Den1[11]	Prev, Den1	Prev, OV, Den 1	Prev	Prev	Prev	Prev	Prev, 3 PCP/MH OV, Den1	Prev, 3 PCP/MH OV, Den1	Prev, 3 PCP/MH OV, Den1	Prev	Prev	Prev, UC, OV, Den1[11]	Prev, 3 PCP/MH, Den1	Prev	Prev	Prev, 3 PCP/MH OV, Den1
	Prescription (Rx) Ded.	$0	$100[8]	$300[78]	$900[8]	See above	See above	See above	See above	See above	See above	See above	See above	See above	See above	$250/$500	$600/$1,200[7]	$350/$700	See above	See above
	Waived for:	N/A ($0 Ded)	Rx Generic	Rx Generic	Not Waived	Rx Generic	Rx Wellness	Not Waived	Rx Wellness	Not Waived	Not Waived	Not Waived	Not Waived	Rx Wellness	Rx Wellness	Rx Generic	Not Waived	Not Waived	Not Waived	Rx Generic
Max. Out-of-Pocket (MOOP)	Integrated?	N	N	Y-$6,800/$13,600[7]	Y-$7,350/$14,700	Y - $7,350/$14,700	Y-$6,400/$12,800	Y-$6,400/$12,800	Y-$6,550/$13,100	Y - $6,550/$13,100	Y-$4,500/$9,000	Y-$7,350/$14,700[7]	Y - $7,350/$14,700	Y - $2,750/$5,500	Y - $6,650/$13,300	N	N	Y-$7,350/$14,700	Y - $2,400/$4,800	Y - $7,350/$14,700
	Medical	$1,300/$2,600	$4,500/$9,000	See above	See above	See above	See above	See above	See above	See above	See above	See above	See above	See above	See above	$6,050/$12,100	$6,050/$12,100[7]	See above	See above	See above
	Prescription (Rx)	$1,300/$2,600	$1,300/$2,600	$1,300/$2,600[7]	$1,300/$2,600	See above	$1,350/$2,700[7]	$1,350/$2,700[7]	$1,350/$2,700	$1,350/$2,700	$1,350/$2,700	$1,350/$2,700[7]	See above	$1,350/$2,700	See above	$1,300/$2,600	$1,300/$2,600[7]	$1,300/$2,600	$1,350/$2,700	See above
Stacked, Embedded or Aggregate?[9]		Stacked[6]	Stacked[6]	Stacked[6]	Stacked[6]	Stacked[6]	Aggregate Embedded[610]	Aggregate Embedded[610]	Aggregate Embedded[610]	Aggregate Embedded[610]	Aggregate Embedded[610]	Aggregate Embedded[610]	Aggregate Embedded[610]	Aggregate[6]	Aggregate Embedded[610]	Stacked[6]	Stacked[6]	Stacked[6]	Aggregate[6]	Stacked[6]
Service Category (Examples)		Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)
Preventive (Prev)		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Office Visit (OV)	PCP or Mental Health (PCP/MH)	$10	$15	$25	Ded., then $35	$40	Ded., then 10%	Ded., then 10%	Ded., then 50%	Ded., then 50%	3 visits/person (9/family) with no cost-share; then deductible applies + co-pay: $20 (Gold), $30 (Silver), $0 (Bronze)			Ded., then $0	Ded., then $0	$15	$30 x 3, then Ded.	Ded., then $40	Ded., then 0%	$0 x3 then deductible
	Specialist[2]	$30	$30	$75	Ded., then $90	$100	Ded., then 30%	Ded., then 30%	Ded., then 50%	Ded., then 50%	Ded., then $30	Ded., then $50	Ded., then $0	Ded., then $0	Ded., then $0	$30	Ded., then $60	Ded., then $100	Ded., then 0%	Ded., then $0
Urgent Care (UC)		$40	$40	$85	Ded., then $100	Ded., then $0	Ded., then 30%	Ded., then 30%	Ded., then 50%	Ded., then 50%	Ded., then $30	Ded., then $50	Ded., then $0	Ded., then $0	Ded., then $0	$30	Ded., then $60	Ded., then $100	Ded., then 0%	Ded., then $0
Ambulance (Amb)		$50	$50	$100	Ded., then $100	Ded., then $0	Ded., then 30%	Ded., then 30%	Ded., then 50%	Ded., then 50%	Ded., then $30	Ded., then $50	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then $50	Ded., then $100	Ded., then $100	Ded., then 0%	Ded., then $0
Emergency Room (ER)[3]		Ded, then $100	Ded, then $150	Ded., then $250	Ded., then 50%	Ded., then $0	Ded., then 30%	Ded., then 30%	Ded., then 50%	Ded., then 50%	Ded., then $250	Ded., then $400	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then $250	Ded., then $400	Ded., then 50%	Ded., then 0%	Ded., then $0
Hospital Services[4]	Inpatient	Ded., then 10%	Ded., then 30%	Ded., then 40%	Ded., then 50%	Ded., then $0	Ded., then 30%	Ded., then 30%	Ded., then 50%	Ded., then 50%	Ded., then $500	Ded., then $1,500	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then 20%	Ded., then 50%	Ded., then 50%	Ded., then 0%	Ded., then $0
	Outpatient	Ded., then 10%	Ded., then 30%	Ded., then 40%	Ded., then 50%	Ded., then $0	Ded., then 30%	Ded., then 30%	Ded., then 50%	Ded., then 50%	Ded., then $500	Ded., then $1,500	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then 20%	Ded., then $1,400	Ded., then 50%	Ded., then 0%	Ded., then $0
Prescription (Rx) Drug Coverage		30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply
Rx Generic[5]		$5	$5	$15	Ded., then $20	$25	Ded.[9], then $10	Ded.[9], then $10	Ded.[9], then $12	Ded., then $12	Ded., then $5	Ded., then $5	Ded.[9], then $0	Ded.[9], then $0	Ded.[9], then $0	$5	Ded., then $5	Ded.[9], then $20	Ded., then 0%	$30
Rx Preferred Brand[5]		$50	Ded., then $50	Ded., then $60	Ded., then $85	Ded.[9], then $0	Ded.[9], then $40	Ded.[9], then $40	Ded.[9], then 40%	Ded., then 40%	Ded., then 40%	Ded., then 40%	Ded.[9], then $0	Ded.[9], then $0	Ded.[9], then $0	Ded., then $40	Ded., then 50%	Ded.[9], then $90	Ded., then 0%	Ded.[9], then $0
Rx Non-Preferred Brand[5]		50%	Ded., then 50%	Ded., then 50%	Ded., then 60%	Ded., then $0	Ded., then 50%	Ded., then 50%	Ded., then 60%	Ded., then 60%	Ded., then 60%	Ded., then 60%	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then 50%	Ded., then 50%	Ded., then 60%	Ded., then 0%	Ded., then $0
Additional Benefits																				
Wellness Benefits		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Up to $300 in wellness rewards per adult					VBID Rx co-pay of $1/$3, up to $50 in wellness rewards			N/A	VBID Rx co-pay of $1/$3, up to $50 in wellness rewards
Premiums by Tier		Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy
Single	BCBSVT	$751.92	$657.15	$561.02	$488.26	$499.22	$571.48		$492.22		$633.59	$549.55	$484.78	$607.36	$484.56					
	MVP	$705.42	$596.79	$528.79	$425.27	$456.68		$505.48		$429.17						$604.43	$474.08	$425.35	$568.54	$422.10
Couple	BCBSVT	$1,503.84	$1,314.30	$1,122.04	$976.52	$998.44	$1,142.96		$984.44		$1,267.18	$1,099.10	$969.56	$1,214.72	$969.12					
	MVP	$1,410.84	$1,193.58	$1,057.58	$850.54	$913.36		$1,010.96		$858.34						$1,208.86	$948.16	$850.70	$1,137.08	$844.20
Parent and Child(ren)	BCBSVT	$1,451.21	$1,268.30	$1,082.77	$942.34	$963.49	$1,102.96		$949.98		$1,222.83	$1,060.63	$935.63	$1,172.20	$935.20					
	MVP	$1,361.46	$1,151.80	$1,020.56	$820.77	$881.39		$975.58		$828.30						$1,166.55	$914.97	$820.93	$1,097.28	$814.65
Family	BCBSVT	$2,112.90	$1,846.59	$1,576.47	$1,372.01	$1,402.81	$1,605.86		$1,383.14		$1,780.39	$1,544.24	$1,362.23	$1,706.68	$1,361.61					
	MVP	$1,982.23	$1,676.98	$1,485.90	$1,195.01	$1,283.27		$1,420.40		$1,205.97						$1,698.45	$1,332.16	$1,195.23	$1,597.60	$1,186.10

Footnotes
1 Medical Deductible waived for: Preventive, Office Visit, Urgent Care, Ambulance, Emergency Room, Pediatric Dental Class 1 Series (as indicated by plan).
2 Specialist co-pay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.
3 ER co-pay is waived if admitted.
4 Hospital Services are Inpatient (including surgery, ICU/NICU, maternity, SNF and MH/SA); Outpatient (including ambulatory surgery centers); and Radiology (MRI, CT, PET). This cost-sharing will also include physician and anesthesia costs, as appropriate.
5 Each insurance carrier classifies drugs according to its own formulary. To see if a specific drug qualifies for the Generic or Preferred co-pay, view the formularies at http://info.healthconnect.vermont.gov/healthplans or contact BCBSVT (800-247-2583) or MVP (844-865-0250).
6 With an aggregate family deductible, your family must meet the family deductible before the plan pays benefits. With a stacked deductible, the plan pays benefits once you meet either your individual deductible or your family deductible.
7 If you purchase a silver plan and your income qualifies for cost-sharing reductions (for example, up to $72,900 for a family of four), your deductible and max. out-of-pocket could be lower than the figures stated above. To learn more, go to www.VermontHealthConnect.gov and click on "Health Plans."
8 BCBSVT Standard Gold/Silver/Bronze plans have a $100/$300/$900 Rx Deductible per person; while MVP Standard Gold/Silver/Bronze plans have an Rx Deductible of $100/$300/$900 for a Single plan or $200/$600/$1,800 for a family plan.
9 With High Deductible Health Plans (HDHP), you do not have to pay the deductible for Wellness prescriptions. See the BCBSVT and MVP lists of Wellness drugs at http://info.healthconnect.vermont.gov/healthplans.
10 Some aggregate family deductibles have an embedded individual maximum out-of-pocket of $7,350 to prevent one individual from paying the full family maximum out-of-pocket when it exceeds the federal maximum out-of-pocket of $7,350 for an individual.
11 This plan includes deductible-waived vision care for qualifying children. See Summary of Benefits and Coverage for details: http://info.healthconnect.vermont.gov/healthplans#SBCs

Abbreviations– Ded: Deductible, Rx: Prescription Drugs, OV: Office Visits, UC: Urgent Care, Amb: Ambulance, VBID: Value-Based Insurance Design, Den1: Pediatric DentalClass 1 Series, ER: Emergency Room
Glossary– Find definitions for VBID, Stacked, Aggregated, Integrated, and other terms at http://info.healthconnect.vermont.gov/glossary.
Plan details – Different plans cover specific drugs and services in different ways. For specifics, contact BCBSVT (800-247-2583) or MVP (844-865-0250).

Updated 10/12/17

VERMONT HEALTH CONNECT
Find the plan that's right for you.

2018

SILVER 73 PLANS

VERMONT HEALTH CONNECT
Find the plan that's right for you.

Check out VermontHealthConnect.gov
or call 1-855-899-9600 (toll-free).

Facebook: Vermont Health Connect

THREE STEPS TO CHOOSING A HEALTH PLAN

STEP 1
BRUSH UP ON HEALTH INSURANCE BASICS.
Think about the kinds of medical care and prescriptions you need now and in the future. Some good resources to get started are at VermontHealthConnect.gov.

STEP 2
SEE IF YOU QUALIFY FOR FINANCIAL HELP.
Take 10 minutes with our Plan Comparison Tool to see monthly payments, likely out-of-pocket costs, and financial help to lower your bills. The Plan Comparison Tool is at VermontHealthConnect.gov.

STEP 3
MAKE YOUR CHOICE.
Use the information from steps 1 and 2 to help you decide which plan is right for you. These plan brochures have detailed information and can help guide you.

OTHER PLAN BROCHURES: PLATINUM & GOLD, SILVER 73, SILVER 77, SILVER 87, SILVER 94, BRONZE

IF YOU MISSED STEPS 1 OR 2, CLICK ON 'GET STARTED' AT VERMONTHEALTHCONNECT.GOV, CALL US AT 1-855-899-9600 (TOLL-FREE), OR MAKE AN APPOINTMENT WITH AN ASSISTER NEAR YOU.

DVHA does not exclude people from its programs, deny them benefits, or treat them unfairly because of race, color, national origin, age, disability, or sex.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-899-9600 (ATS : 711). (French)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-899-9600 (TTY: 711). (Spanish)

VERMONT

Vermont Health Connect is
Vermont's Health Insurance Marketplace.

Health benefit plans offered by:

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

MVP HEALTH CARE

2018 SILVER 73 PLANS

		Standard Plans			Blue Rewards	MVP VT Plus	IMPORTANT INFORMATION
		Silver 73%	Silver CDHP 73% (HDHP)		Silver 73%	Silver 73%	**All Vermont Health Connect plans cover the same set of essential health benefits. The difference is in how you pay for these benefits.** Standard plans have the same designs across insurance carriers, while Blue Rewards and MVP VT Plus plans were uniquely designed by their carriers, with an emphasis on wellness. Before selecting a health plan, be sure to check the out-of-pocket costs for prescription drugs and medical services.
		BCBSVT & MVP	BCBSVT	MVP	BCBSVT[4]	MVP[4]	
On average, these plans cover 73% of health care costs. You may qualify for lower out-of-pocket costs. Check the Subsidy Estimator at VermontHealthConnect.gov.		**Individual/Family**	**Individual/Family[3]** Can be paired with a Health Savings Account	**Individual/Family[3]** Can be paired with a Health Savings Account	**Individual/Family**	**Individual/Family**	*Out-of-pocket costs – health care costs, such as deductible, co-pay, and co-insurance that are not covered by insurance. The premium is not considered an out-of-pocket cost.* *Deductible – the amount you must pay for non-waived services before health insurance begins to pay.* *Maximum Out-of-Pocket – the most you could pay in out-of-pocket costs in a year if you had serious medical needs. Add this amount to your annual premium to find your worst-case scenario.*
Deductible & Maximum Out-of-Pocket							
Cost-Sharing Reductions Available for Individuals Who Qualify		Yes	Yes	Yes	Yes	Yes	If your income qualifies and you buy a silver-level plan, you may benefit from lower out-of-pocket costs (more like a gold or platinum plan) at the price of a silver plan. Only available with silver plans.
Deductible	Integrated Deductible	No	Yes - $1,550/$3,100	Yes - $1,550/$3,100	Yes - $2,100/$4,200	No	If integrated, prescription (Rx) expenses and medical expenses both contribute to a single deductible.
	Medical Deductible	$2,550/$5,100	See Integrated (above)	See Integrated (above)	See Integrated (above)	$1,100/$2,200	The deductible for medical services (doctor appointments, hospital stays, etc.).
	Medical Deductible waived for	Preventive, Office Visits, Urgent Care, Ambulance	Preventive	Preventive	Preventive, 3 Office Visits	Preventive, 3 Primary Care or Mental Health Office Visits	The health plan pays for these services even before you meet your deductible. You just pay the co-pay below.
	Prescription (Rx) Deductible	$300/$600	See Integrated (above)	See Integrated (above)	See Integrated (above)	$300/$600	The deductible for prescription drugs.
	Rx Deductible Waived for	Generic Drugs	Wellness Drugs	Wellness Drugs	Not Waived	Not Waived	Items that are covered prior to the prescription deductible being met. Wellness drugs are prescribed to prevent a disease or condition or help you manage an existing issue. Value-Based Insurance Design (VBID) covers maintenance medication for members with some chronic conditions. You just pay the co-pay below.
Max Out-of-Pocket	Integrated Max Out-of-Pocket	Yes - $5,700/$11,400	Yes - $4,100/$8,200	Yes - $4,100/$8,200	Yes - $5,700/$11,400	No	If integrated, prescription (Rx) expenses contribute to overall maximum out-of-pocket as well as Rx maximum out-of-pocket.
	Medical Max Out-of-Pocket	See Integrated (above)	See Integrated (above)	See Integrated (above)	See Integrated (above)	$4,550/$9,100	The most individuals or families will pay for covered services per year.
	Rx Max Out-of-Pocket	$1,200/$2,400	$1,350/$2,700	$1,350/$2,700	$1,350/$2,700	$1,300/$2,600	The most individuals or families will pay for prescription drugs per year.
Family Deductible/Max Out-of-Pocket (Stacked/ Aggregate/Embedded)		Stacked Deductible/ Stacked MOOP	Aggregate Deductible/ Embedded MOOP	Aggregate Deductible/ Embedded MOOP	Aggregate Deductible/ Embedded MOOP	Stacked Deductible/ Stacked MOOP	Doesn't apply to individual plans. With aggregate, you must meet the family amount before the plan pays benefits. With stacked, the plan pays benefits once you meet your individual or family amount. An embedded MOOP ensures that no individual pays more than $7,350 in out-of-pocket costs (a requirement for all qualified health plans).
SERVICE CATEGORY		Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	*Categories for the different types of care provided by the plans. Co-pay=$ you pay / Co-insurance=% you pay*
Preventive (Prev)		$0	$0	$0	$0	$0	Care that includes screenings, tests, and counseling to prevent you from getting sick or to detect health conditions early. For lists of preventive services, go to VermontHealthConnect.gov and click on 'Health Plans.'
Office Visit (OV)	Primary Care Physician or Mental Health	$25	Deductible, then 10%	Deductible, then 10%	3 visits, then deductible, then $30	3 visits at $30, then deductible, then $30	Office visit with a primary care provider or mental health professional.
	Specialist Office Visit	$65	Deductible, then 25%	Deductible, then 25%	Deductible, then $50	Deductible, then $60	Office visit with a care provider who focuses on a specific area of medicine (e.g. dermatologist), as well as physical therapy, occupational therapy, and covered alternative treatment benefits.
Urgent Care (UC)		$75	Deductible, then 25%	Deductible, then 25%	Deductible, then $50	Deductible, then $60	A type of walk-in clinic open seven days a week that primarily treats injuries or illness requiring immediate care, but not serious enough to require an ER visit.
Ambulance (Amb)		$100	Deductible, then 25%	Deductible, then 25%	Deductible, then $50	Deductible, then $100	Cost of an ambulance in case of emergency.
Emergency Room (ER)		Deductible, then $250	Deductible, then 25%	Deductible, then 25%	Deductible, then $400	Deductible, then $350	Emergency services you get in an emergency room. ER co-pay/co-insurance is waived if you are admitted to hospital.
Hospital Services		Deductible, then 40%	Deductible, then 25%	Deductible, then 25%	Deductible, then $1,500	Deductible, then 50%	Includes: Inpatient (including surgery, ICU/NICU, maternity, skilled nursing facilities, mental health, and substance abuse); Outpatient (including ambulatory surgery centers); Radiology (MRI, CT, PET).
Rx DRUG COVERAGE (30-day supply)		Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	*Different levels of prescription drug coverage offered by the plan.*
Rx Generic		$12	Deductible, then $10	Deductible, then $10	Deductible, then $5	Deductible, then $5	"Generic" typically applies to prescription drugs that have the same active ingredient formulas as brand-name drugs.
Rx Preferred Brand		Deductible, then $60	Deductible, then $40	Deductible, then $40	Deductible, then 40%	Deductible, then 50%	"Preferred" and "Non-preferred" are set by each insurance carrier. To find how specific drugs are categorized, go to VermontHealthConnect.gov and click on "Health Plans" or call BCBSVT (800-247-2583) or MVP (844-865-0250). For an exact list of medications in each category, please refer to the carriers' drug lists at http://info.healthconnect.vermont.gov/healthplans#Rx.
Rx Non-Preferred Brand		Deductible, then 50%	Deductible, then 50%	Deductible, then 50%	Deductible, then 60%	Deductible, then 50%	
ADDITIONAL BENEFITS							*This is a partial list. See additional benefits in each plan's Summary of Benefits and Coverage.*
Pediatric Dental & Vision		Yes	Yes, after deductible	Yes, after deductible	Yes, after deductible	Yes, after deductible	Included in the medical plan for children up to 21. Some services are subject to the medical deductible. See plan materials for details.
Wellness Benefits							
MONTHLY PREMIUMS BY TIERS		Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	
SINGLE	BCBSVT	$561.02	$571.48	N/A	549.55	N/A	
	MVP	$528.79	N/A	$505.48	N/A	474.08	
COUPLE	BCBSVT	$1,122.04	$1,142.96	N/A	$1,099.10	N/A	
	MVP	$1,057.58	N/A	$1,010.96	N/A	$948.16	
PARENT AND CHILD(REN)	BCBSVT	$1,082.77	$1,102.96	N/A	$1,060.63	N/A	
	MVP	$1,020.56	N/A	$975.58	N/A	$914.97	
FAMILY	BCBSVT	$1,576.47	$1,605.86	N/A	$1,544.24	N/A	
	MVP	$1,485.90	N/A	$1,420.40	N/A	$1,332.16	

FINANCIAL HELP: APTC & CSR

If you buy health insurance on your own (not through your employer), you may qualify for financial help. For example, a family of four with an income of up to $98,400 may qualify for Advanced Premium Tax Credits (APTC) to help pay for premiums. A family of four with an income up to $73,800 may also qualify for lower out-of-pocket costs through Cost-Sharing Reductions (CSR). This means that instead of covering 70% of health care costs on average, the enhanced silver plan will cover between 73% and 94% of costs. You can use APTC to purchase a plan in any metal level, but you can only get CSR with silver plans. To see how your particular premiums and out-of-pocket costs might be reduced, see the Subsidy Estimator at VermontHealthConnect.gov or call 1-855-899-9600 (toll-free).

REMINDER

Once confirmed, plan selections cannot be changed until the next open enrollment period, unless someone in your household has a qualifying event, such as a birth, death or a new job. If your health coverage is cancelled due to non-payment, you may not be able to get coverage again until the following January.

[1] BCBSVT Standard Silver has a $300 Rx Deductible per person, while the Rx Deductible for MVP Standard Silver is $300 for a single plan or $600 for all other tiers.

[2] Combined 3/6/9 visits PCP/MH with no cost-share; then deductible applies with $30 co-pay.

[3] High-deductible health plans (HDHP) can be combined with a health savings account (HSA) to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

[4] Costs may vary by service. Please consult your issuer's documents for complete details.

VERMONT HEALTH CONNECT
Find the plan that's right for you.

2018

SILVER 77 PLANS

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Facebook: Vermont Health Connect

THREE STEPS TO CHOOSING A HEALTH PLAN

STEP 1
BRUSH UP ON HEALTH INSURANCE BASICS.
Think about the kinds of medical care and prescriptions you need now and in the future. Some good resources to get started are at VermontHealthConnect.gov.

STEP 2
SEE IF YOU QUALIFY FOR FINANCIAL HELP.
Take 10 minutes with our Plan Comparison Tool to see monthly payments, likely out-of-pocket costs, and financial help to lower your bills. The Plan Comparison Tool is at VermontHealthConnect.gov.

STEP 3
MAKE YOUR CHOICE.
Use the information from steps 1 and 2 to help you decide which plan is right for you. These plan brochures have detailed information and can help guide you.

OTHER PLAN BROCHURES: PLATINUM & GOLD, SILVER 73, SILVER 77, SILVER 87, SILVER 94, BRONZE

IF YOU MISSED STEPS 1 OR 2, CLICK ON 'GET STARTED' AT VERMONTHEALTHCONNECT.GOV, CALL US AT 1-855-899-9600 (TOLL-FREE), OR MAKE AN APPOINTMENT WITH AN ASSISTER NEAR YOU.

DVHA does not exclude people from its programs, deny them benefits, or treat them unfairly because of race, color, national origin, age, disability, or sex.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-899-9600 (ATS : 711). (French)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-899-9600 (TTY: 711). (Spanish)

VERMONT

Vermont Health Connect is
Vermont's Health Insurance Marketplace.

Health benefit plans offered by:

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

MVP HEALTH CARE

2018 SILVER 77 PLANS

		Standard Plans			Blue Rewards	MVP VT Plus	IMPORTANT INFORMATION
On average, these plans cover 77% of health care costs. You may qualify for lower out-of-pocket costs. Check the Subsidy Estimator at VermontHealthConnect.gov.		Silver 77%	Silver CDHP 77% (HDHP)		Silver 77%	Silver 77	**All Vermont Health Connect plans cover the same set of essential health benefits. The difference is in how you pay for these benefits.** Standard plans have the same designs across insurance carriers, while Blue Rewards and MVP VT Plus plans were uniquely designed by their carriers, with an emphasis on wellness. Before selecting a health plan, be sure to check the out-of-pocket costs for prescription drugs and medical services.
		BCBSVT & MVP	BCBSVT	MVP	BCBSVT[4]	MVP[4]	
Deductible & Maximum Out-of-Pocket		**Individual/Family**	**Individual/Family[3]** Can be paired with a Health Savings Account	**Individual/Family[3]** Can be paired with a Health Savings Account	**Individual/Family**	**Individual/Family**	*Out-of-pocket costs – health care costs, such as deductible, co-pay, and co-insurance that are not covered by insurance. The premium is not considered an out-of-pocket cost.* *Deductible – the amount you must pay for non-waived services before health insurance begins to pay.* *Maximum Out-of-Pocket – the most you could pay in out-of-pocket costs in a year if you had serious medical needs. Add this amount to your annual premium to find your worst-case scenario.*
Cost-Sharing Reductions Available for Individuals Who Qualify		Yes	Yes	Yes	Yes	Yes	If your income qualifies and you buy a silver-level plan, you may benefit from lower out-of-pocket costs (more like a gold or platinum plan) at the price of a silver plan. Only available with silver plans.
Deductible	Integrated Deductible	No	Yes - $1,300/$2,600	Yes - $1,350/$2,700	Yes - $1,000/$2,000	No	If integrated, prescription (Rx) expenses and medical expenses both contribute to a single deductible.
	Medical Deductible	$2,000/$4,000	See Integrated (above)	See Integrated (above)	See Integrated (above)	$300/$600	The deductible for medical services (doctor appointments, hospital stays, etc.).
	Medical Deductible waived for	Preventive, Office Visits, Urgent Care, Ambulance	Preventive	Preventive	Preventive, 3 Office Visits	Preventive, 3 Primary Care or Mental Health Office Visits	The health plan pays for these services even before you meet your deductible. You just pay the co-pay below.
	Prescription (Rx) Deductible	$200/$400	See Integrated (above)	See Integrated (above)	See Integrated (above)	$100/$200	The deductible for prescription drugs.
	Rx Deductible Waived for	Generic Drugs	Wellness Drugs	Wellness Drugs	Not Waived	Not Waived	Items that are covered prior to the prescription deductible being met. Wellness drugs are prescribed to prevent a disease or condition or help you manage an existing issue. Value-Based Insurance Design (VBID) covers maintenance medication for members with some chronic conditions. You just pay the co-pay below.
Max Out-of-Pocket	Integrated Max Out-of-Pocket	Yes - $4,500/$9,000	Yes - $3,000/$6,000	Yes - $3,000/$6,000	Yes - $5,200/$10,400	No	If integrated, prescription (Rx) expenses contribute to overall maximum out-of-pocket as well as Rx maximum out-of-pocket.
	Medical Max Out-of-Pocket	See Integrated (above)	See Integrated (above)	See Integrated (above)	See Integrated (above)	$4,500/$9,000	The most individuals or families will pay for covered services per year.
	Rx Max Out-of-Pocket	$1,000/$2,000	$1,350/$2,700	$1,350/$2,700	$1,350/$2,700	$1,300/$2,600	The most individuals or families will pay for prescription drugs per year.
Family Deductible/Max Out-of-Pocket (Stacked/ Aggregate/Embedded)		Stacked Deductible/ Stacked MOOP	Aggregate Deductible/ Embedded MOOP	Aggregate Deductible/ Aggregate MOOP	Aggregate Deductible/ Embedded MOOP	Stacked Deductible/ Stacked MOOP	Doesn't apply to individual plans. With aggregate, you must meet the family amount before the plan pays benefits. With stacked, the plan pays benefits once you meet your individual or family amount. An embedded MOOP ensures that no individual pays more than $7,350 in out-of-pocket costs (a requirement for all qualified health plans).
SERVICE CATEGORY		Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	*Categories for the different types of care provided by the plans. Co-pay=$ you pay / Co-insurance=% you pay*
Preventive (Prev)		$0	$0	$0	$0	$0	Care that includes screenings, tests, and counseling to prevent you from getting sick or to detect health conditions early. For lists of preventive services, go to VermontHealthConnect.gov and click on 'Health Plans.'
Office Visit (OV)	Primary Care Physician or Mental Health	$20	Deductible, then 10%	Deductible, then 10%	3 visits, then deductible, then $30	3 visits at $10, then deductible, then $10	Office visit with a primary care provider or mental health professional.
	Specialist Office Visit	$40	Deductible, then 25%	Deductible, then 25%	Deductible, then $50	Deductible, then $40	Office visit with a care provider who focuses on a specific area of medicine (e.g. dermatologist), as well as physical therapy, occupational therapy, and covered alternative treatment benefits.
Urgent Care (UC)		$50	Deductible, then 25%	Deductible, then 25%	Deductible, then $50	Deductible, then $40	A type of walk-in clinic open seven days a week that primarily treats injuries or illness requiring immediate care, but not serious enough to require an ER visit.
Ambulance (Amb)		$100	Deductible, then 25%	Deductible, then 25%	Deductible, then $50	Deductible, then $100	Cost of an ambulance in case of emergency.
Emergency Room (ER)		Deductible, then $250	Deductible, then 25%	Deductible, then 25%	Deductible, then $400	Deductible, then $100	Emergency services you get in an emergency room. ER co-pay/co-insurance is waived if you are admitted to hospital.
Hospital Services		Deductible, then 40%	Deductible, then 25%	Deductible, then 25%	Deductible, then $1,500	Deductible, then 30%	Includes: Inpatient (including surgery, ICU/NICU, maternity, skilled nursing facilities, mental health, and substance abuse); Outpatient (including ambulatory surgery centers); Radiology (MRI, CT, PET).
Rx DRUG COVERAGE (30-day supply)		Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	*Different levels of prescription drug coverage offered by the plans.*
Rx Generic		$12	Deductible, then $10	Deductible, then $10	Deductible, then $5	Deductible, then $5	"Generic" typically applies to prescription drugs that have the same active ingredient formulas as brand-name drugs.
Rx Preferred Brand		Deductible, then $60	Deductible, then $40	Deductible, then $40	Deductible, then 40%	Deductible, then 40%	"Preferred" and "Non-preferred" are set by each insurance carrier. To find how specific drugs are categorized, go to VermontHealthConnect.gov and click on "Health Plans" or call BCBSVT (800-247-2583) or MVP (844-865-0250). For an exact list of medications in each category, please refer to the carriers' drug lists at http://info.healthconnect.vermont.gov/healthplans#Rx.
Rx Non-Preferred Brand		Deductible, then 50%	Deductible, then 50%	Deductible, then 50%	Deductible, then 60%	Deductible, then 40%	
ADDITIONAL BENEFITS							*This is a partial list. See additional benefits in each plan's Summary of Benefits and Coverage.*
Pediatric Dental & Vision		Yes	Yes, after deductible	Yes, after deductible	Yes, after deductible	Yes, after deductible	Included in the medical plan for children up to 21. Some services are subject to the medical deductible. See plan materials for details.
Wellness Benefits							
MONTHLY PREMIUMS BY TIERS		Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	
SINGLE	BCBSVT	$561.02	$571.48	N/A	549.55	N/A	
	MVP	$528.79	N/A	$505.48	N/A	474.08	
COUPLE	BCBSVT	$1,122.04	$1,142.96	N/A	$1,099.10	N/A	
	MVP	$1,057.58	N/A	$1,010.96	N/A	$948.16	
PARENT AND CHILD(REN)	BCBSVT	$1,082.77	$1,102.96	N/A	$1,060.63	N/A	
	MVP	$1,020.56	N/A	$975.58	N/A	$914.97	
FAMILY	BCBSVT	$1,576.47	$1,605.86	N/A	$1,544.24	N/A	
	MVP	$1,485.90	N/A	$1,420.40	N/A	$1,332.16	

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[1] BCBSVT Standard Silver has a $300 Rx Deductible per person, while the Rx Deductible for MVP Standard Silver is $300 for a single plan or $600 for all other tiers.

[2] Combined 3/6/9 visits PCP/MH with no cost-share; then deductible applies with $30 co-pay.

[3] High-deductible health plans (HDHP) can be combined with a health savings account (HSA) to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

[4] Costs may vary by service. Please consult your issuer's documents for complete details.

VERMONT HEALTH CONNECT
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SILVER 87 PLANS

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Take 10 minutes with our Plan Comparison Tool to see monthly payments, likely out-of-pocket costs, and financial help to lower your bills. The Plan Comparison Tool is at VermontHealthConnect.gov.

STEP 3
MAKE YOUR CHOICE.
Use the information from steps 1 and 2 to help you decide which plan is right for you. These plan brochures have detailed information and can help guide you.

OTHER PLAN BROCHURES: PLATINUM & GOLD, SILVER 73, SILVER 77, SILVER 87, SILVER 94, BRONZE

IF YOU MISSED STEPS 1 OR 2, CLICK ON 'GET STARTED' AT VERMONTHEALTHCONNECT.GOV, CALL US AT 1-855-899-9600 (TOLL-FREE), OR MAKE AN APPOINTMENT WITH AN ASSISTER NEAR YOU.

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ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-899-9600 (ATS : 711). (French)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-899-9600 (TTY: 711). (Spanish)

VERMONT

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Health benefit plans offered by:

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

MVP HEALTH CARE

2018 SILVER 87 PLANS

		Standard Plans			Blue Rewards	MVP VT Plus	IMPORTANT INFORMATION
On average, these plans cover 87% of health care costs. You may qualify for lower out-of-pocket costs. Check the Subsidy Estimator at VermontHealthConnect.gov.		Silver 87%	Silver CDHP 87% (HDHP)		Silver 87%	Silver 87	**All Vermont Health Connect plans cover the same set of essential health benefits. The difference is in how you pay for these benefits.** Standard plans have the same designs across insurance carriers, while Blue Rewards and MVP VT Plus plans were uniquely designed by their carriers, with an emphasis on wellness. Before selecting a health plan, be sure to check the out-of-pocket costs for prescription drugs and medical services.
		BCBSVT & MVP	BCBSVT	MVP	BCBSVT[3]	MVP[3]	
		Individual/Family	**Individual/Family**	**Individual/Family**	**Individual/Family**	**Individual/Family**	*Out-of-pocket costs – health care costs, such as deductible, co-pay, and co-insurance that are not covered by insurance. The premium is not considered an out-of-pocket cost.*
Deductible & Maximum Out-of-Pocket							*Deductible – the amount you must pay for non-waived services before health insurance begins to pay.*
							Maximum Out-of-Pocket – the most you could pay in out-of-pocket costs in a year if you had serious medical needs. Add this amount to your annual premium to find your worst-case scenario.
Cost-Sharing Reductions Available for Individuals Who Qualify		Yes	Yes	Yes	Yes	Yes	If your income qualifies and you buy a silver-level plan, you may benefit from lower out-of-pocket costs (more like a gold or platinum plan) at the price of a silver plan. Only available with silver plans.
Deductible	Integrated Deductible	No	Yes - $1,200/$2,400	Yes - $1,200/$2,400	Yes - $200/$400	No	If integrated, prescription (Rx) expenses and medical expenses both contribute to a single deductible.
	Medical Deductible	$800/$1,600	See Integrated (above)	See Integrated (above)	See Integrated (above)	$0	The deductible for medical services (doctor appointments, hospital stays, etc.).
	Medical Deductible waived for	Preventive, Office Visits, Urgent Care, Ambulance	Preventive	Preventive	Preventive, 3 Office Visits	N/A	The health plan pays for these services even before you meet your deductible. You just pay the co-pay below.
	Prescription (Rx) Deductible	$150/$300	See Integrated (above)	See Integrated (above)	See Integrated (above)	See integrated (above)	The deductible for prescription drugs.
	Rx Deductible Waived for	Generic Drugs	Wellness Drugs	Wellness Drugs	Not Waived	N/A	Items that are covered prior to the prescription deductible being met. Wellness drugs are prescribed to prevent a disease or condition or help you manage an existing issue. Value-Based Insurance Design (VBID) covers maintenance medication for members with some chronic conditions. You just pay the co-pay below.
Max Out-of-Pocket	Integrated Max Out-of-Pocket	Yes - $1,600/$3,200	Yes - $1,200/$2,400	Yes - $1,200/$2,400	Yes - $2,000/$4,000	No	If integrated, prescription (Rx) expenses contribute to overall maximum out-of-pocket as well as Rx maximum out-of-pocket.
	Medical Max Out-of-Pocket	See Integrated (above)	See Integrated (above)	See Integrated (above)	See Integrated (above)	$2,000/$4,000	The most individuals or families will pay for covered services per year.
	Rx Max Out-of-Pocket	$400/$800	N/A	N/A	$1,350/$2,700	$450/$900	The most individuals or families will pay for prescription drugs per year.
Family Deductible/Max Out-of-Pocket (Stacked/ Aggregate/Embedded)		Stacked Deductible/ Stacked MOOP	Aggregate Deductible/ Embedded MOOP	Aggregate Deductible/ Aggregate MOOP	Aggregate Deductible/ Embedded MOOP	Stacked Deductible/ Stacked MOOP	Doesn't apply to individual plans. With aggregate, you must meet the family amount before the plan pays benefits. With stacked, the plan pays benefits once you meet your individual or family amount. An embedded MOOP ensures that no individual pays more than $7,350 in out-of-pocket costs (a requirement for all qualified health plans).
SERVICE CATEGORY		Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	*Categories for the different types of care provided by the plans. Co-pay=$ you pay / Co-insurance=% you pay*
Preventive (Prev)		$0	$0	$0	$0	$0	Care that includes screenings, tests, and counseling to prevent you from getting sick or to detect health conditions early. For lists of preventive services, go to VermontHealthConnect.gov and click on 'Health Plans.'
Office Visit (OV)	Primary Care Physician or Mental Health	$10	Deductible, then $0	Deductible, then $0	Deductible, then $30	$5	Office visit with a primary care provider or mental health professional.
	Specialist Office Visit	$30	Deductible, then $0	Deductible, then $0	Deductible, then $50	$30	Office visit with a care provider who focuses on a specific area of medicine (e.g. dermatologist), as well as physical therapy, occupational therapy, and covered alternative treatment benefits.
Urgent Care (UC)		$40	Deductible, then $0	Deductible, then $0	Deductible, then $50	$30	A type of walk-in clinic open seven days a week that primarily treats injuries or illness requiring immediate care, but not serious enough to require an ER visit.
Ambulance (Amb)		$100	Deductible, then $0	Deductible, then $0	Deductible, then $50	$50	Cost of an ambulance in case of emergency.
Emergency Room (ER)		Deductible, then $250	Deductible, then $0	Deductible, then $0	Deductible, then $250	$50	Emergency services you get in an emergency room. ER co-pay/co-insurance is waived if you are admitted to hospital.
Hospital Services		Deductible, then 40%	Deductible, then $0	Deductible, then $0	Deductible, then $500	10%	Includes: Inpatient (including surgery, ICU/NICU, maternity, skilled nursing facilities, mental health, and substance abuse); Outpatient (including ambulatory surgery centers); Radiology (MRI, CT, PET).
Rx DRUG COVERAGE (30-day supply)		Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	*Different levels of prescription drug coverage offered by the plan.*
Rx Generic		$10	Deductible, then $0	Deductible, then $0	Deductible, then $5	$5	"Generic" typically applies to prescription drugs that have the same active ingredient formulas as brand-name drugs.
Rx Preferred Brand		Deductible, then $50	Deductible, then $0	Deductible, then $0	Deductible, then 40%	20%	"Preferred" and "Non-preferred" are set by each insurance carrier. To find how specific drugs are categorized, go to VermontHealthConnect.gov and click on "Health Plans" or call BCBSVT (800-247-2583) or MVP (844-865-0250). For an exact list of medications in each category, please refer to the carriers' drug lists at http://info.healthconnect.vermont.gov/healthplans#Rx.
Rx Non-Preferred Brand		Deductible, then 50%	Deductible, then $0	Deductible, then $0	Deductible, then 60%	40%	
ADDITIONAL BENEFITS							*This is a partial list. See additional benefits in each plan's Summary of Benefits and Coverage.*
Pediatric Dental & Vision		Yes	Yes, after deductible	Yes, after deductible	Yes, after deductible	Yes	Included in the medical plan for children up to 21. Some services are subject to the medical deductible. See plan materials for details.
Wellness Benefits							
MONTHLY PREMIUMS BY TIERS		Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	
SINGLE	BCBSVT	$561.02	$571.48	N/A	549.55	N/A	
	MVP	$528.79	N/A	$505.48	N/A	474.08	
COUPLE	BCBSVT	$1,122.04	$1,142.96	N/A	$1,099.10	N/A	
	MVP	$1,057.58	N/A	$1,010.96	N/A	$948.16	
PARENT AND CHILD(REN)	BCBSVT	$1,082.77	$1,102.96	N/A	$1,060.63	N/A	
	MVP	$1,020.56	N/A	$975.58	N/A	$914.97	
FAMILY	BCBSVT	$1,576.47	$1,605.86	N/A	$1,544.24	N/A	
	MVP	$1,485.90	N/A	$1,420.40	N/A	$1,332.16	

FINANCIAL HELP: APTC & CSR

If you buy health insurance on your own (not through your employer), you may qualify for financial help. For example, a family of four with an income of up to $98,400 may qualify for Advanced Premium Tax Credits (APTC) to help pay for premiums. A family of four with an income up to $73,800 may also qualify for lower out-of-pocket costs through Cost-Sharing Reductions (CSR). This means that instead of covering 70% of health care costs on average, the enhanced silver plan will cover between 73% and 94% of costs. You can use APTC to purchase a plan in any metal level, but you can only get CSR with silver plans. To see how your particular premiums and out-of-pocket costs might be reduced, see the Subsidy Estimator at VermontHealthConnect.gov or call 1-855-899-9600 (toll-free).

REMINDER

Once confirmed, plan selections cannot be changed until the next open enrollment period, unless someone in your household has a qualifying event, such as a birth, death or a new job. If your health coverage is cancelled due to non-payment, you may not be able to get coverage again until the following January.

[1] BCBSVT Standard Silver has a $300 Rx Deductible per person, while the Rx Deductible for MVP Standard Silver is $300 for a single plan or $600 for all other tiers.

[2] Combined 3/6/9 visits PCP/MH with no cost-share; then deductible applies with $30 co-pay.

[3] Costs may vary by service. Please consult your issuer's documents for complete details.

VERMONT HEALTH CONNECT
Find the plan that's right for you.

2018

SILVER 94 PLANS

VERMONT HEALTH CONNECT
Find the plan that's right for you.

Check out VermontHealthConnect.gov
or call 1-855-899-9600 (toll-free).

Facebook: Vermont Health Connect

THREE STEPS TO CHOOSING A HEALTH PLAN

STEP 1
BRUSH UP ON HEALTH INSURANCE BASICS.
Think about the kinds of medical care and prescriptions you need now and in the future. Some good resources to get started are at VermontHealthConnect.gov.

STEP 2
SEE IF YOU QUALIFY FOR FINANCIAL HELP.
Take 10 minutes with our Plan Comparison Tool to see monthly payments, likely out-of-pocket costs, and financial help to lower your bills. The Plan Comparison Tool is at VermontHealthConnect.gov.

STEP 3
MAKE YOUR CHOICE.
Use the information from steps 1 and 2 to help you decide which plan is right for you. These plan brochures have detailed information and can help guide you.

OTHER PLAN BROCHURES: PLATINUM & GOLD, SILVER 73, SILVER 77, SILVER 87, SILVER 94, BRONZE

IF YOU MISSED STEPS 1 OR 2, CLICK ON 'GET STARTED' AT VERMONTHEALTHCONNECT.GOV, CALL US AT 1-855-899-9600 (TOLL-FREE), OR MAKE AN APPOINTMENT WITH AN ASSISTER NEAR YOU.

DVHA does not exclude people from its programs, deny them benefits, or treat them unfairly because of race, color, national origin, age, disability, or sex.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-899-9600 (ATS : 711). (French)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-899-9600 (TTY: 711). (Spanish)

VERMONT

Vermont Health Connect is
Vermont's Health Insurance Marketplace.

Health benefit plans offered by:

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

MVP HEALTH CARE

2018 SILVER 94 PLANS

		Standard Plans			Blue Rewards	MVP VT Plus
		Silver 94%	Silver CDHP 94% (HDHP)		Silver 94%	Silver 94
		BCBSVT & MVP	BCBSVT	MVP	BCBSVT[3]	MVP[3]
On average, these plans cover 94% of health care costs. You may qualify for lower out-of-pocket costs. Check the Subsidy Estimator at VermontHealthConnect.gov.		**Individual/Family**	**Individual/Family**	**Individual/Family**	**Individual/Family**	**Individual/Family**
Deductible & Maximum Out-of-Pocket						
Cost-Sharing Reductions Available for Individuals Who Qualify		Yes	Yes	Yes	Yes	Yes
Deductible	Integrated Deductible	No	Yes - $550/$1,100	Yes - $550/$1,100	Yes - $0/$0	No
	Medical Deductible	$150/$300	See Integrated (above)	See Integrated (above)	See Integrated (above)	$0
	Medical Deductible waived for	Preventive, Office Visits, Urgent Care, Ambulance	Preventive	Preventive	Preventive, 3 Office Visits	N/A
	Prescription (Rx) Deductible	N/A	See Integrated (above)	See Integrated (above)	See Integrated (above)	See Integrated (above)
	Rx Deductible Waived for	Generic Drugs	Wellness Drugs	Wellness Drugs	Not Waived	N/A
Max Out-of-Pocket	Integrated Max Out-of-Pocket	Yes - $800/$1,600	Yes - $550/$1,100	Yes - $550/$1,100	Yes - $950/$1,900	No
	Medical Max Out-of-Pocket	See Integrated (above)	See Integrated (above)	See Integrated (above)	See Integrated (above)	$950/$1,900
	Rx Max Out-of-Pocket	$200/$400	N/A	N/A	N/A	$150/$300
Family Deductible/Max Out-of-Pocket (Stacked/Aggregate/Embedded)		Stacked Deductible/ Stacked MOOP	Aggregate Deductible/ Embedded MOOP	Aggregate Deductible/ Aggregate MOOP	Aggregate Deductible/ Embedded MOOP	Stacked Deductible/ Stacked MOOP
SERVICE CATEGORY		Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)
Preventive (Prev)		$0	$0	$0	$0	$0
Office Visit (OV)	Primary Care Physician or Mental Health	$5	Deductible, then $0	Deductible, then $0	$15	$5
	Specialist Office Visit	$15	Deductible, then $0	Deductible, then $0	$35	$10
Urgent Care (UC)		$25	Deductible, then $0	Deductible, then $0	$35	$10
Ambulance (Amb)		$50	Deductible, then $0	Deductible, then $0	$35	$25
Emergency Room (ER)		Deductible, then $75	Deductible, then $0	Deductible, then $0	$250	$25
Hospital Services		Deductible, then 10%	Deductible, then $0	Deductible, then $0	$0	5%
Rx DRUG COVERAGE (30-day supply)		Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)	Co-pay($)/ Co-insurance (%)
Rx Generic		$5	Deductible, then $0	Deductible, then $0	$5	$5
Rx Preferred Brand		$20	Deductible, then $0	Deductible, then $0	40%	5%
Rx Non-Preferred Brand		30%	Deductible, then $0	Deductible, then $0	60%	5%
ADDITIONAL BENEFITS						
Pediatric Dental & Vision		Yes	Yes, after deductible	Yes, after deductible	Yes, after deductible	Yes
Wellness Benefits						
MONTHLY PREMIUMS BY TIERS		Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy
SINGLE	BCBSVT	$561.02	$571.48	N/A	$549.55	N/A
	MVP	$528.79	N/A	$505.48	N/A	$474.08
COUPLE	BCBSVT	$1,122.04	$1,142.96	N/A	$1,099.10	N/A
	MVP	$1,057.58	N/A	$1,010.96	N/A	$948.16
PARENT AND CHILD(REN)	BCBSVT	$1,082.77	$1,102.96	N/A	$1,060.63	N/A
	MVP	$1,020.56	N/A	$975.58	N/A	$914.97
FAMILY	BCBSVT	$1,576.47	$1,605.86	N/A	$1,544.24	N/A
	MVP	$1,485.90	N/A	$1,420.40	N/A	$1,332.16

IMPORTANT INFORMATION

All Vermont Health Connect plans cover the same set of essential health benefits. The difference is in how you pay for these benefits. Standard plans have the same designs across insurance carriers, while Blue Rewards and MVP VT Plus plans were uniquely designed by their carriers, with an emphasis on wellness. Before selecting a health plan, be sure to check the out-of-pocket costs for prescription drugs and medical services.

Out-of-pocket costs – health care costs, such as deductible, co-pay, and co-insurance that are not covered by insurance. The premium is not considered an out-of-pocket cost.

Deductible – the amount you must pay for non-waived services before health insurance begins to pay.

Maximum Out-of-Pocket – the most you could pay in out-of-pocket costs in a year if you had serious medical needs. Add this amount to your annual premium to find your worst-case scenario.

If your income qualifies and you buy a silver-level plan, you may benefit from lower out-of-pocket costs (more like a gold or platinum plan) at the price of a silver plan. Only available with silver plans.

If integrated, prescription (Rx) expenses and medical expenses both contribute to a single deductible.

The deductible for medical services (doctor appointments, hospital stays, etc.).

The health plan pays for these services even before you meet your deductible. You just pay the co-pay below.

The deductible for prescription drugs.

Items that are covered prior to the prescription deductible being met. Wellness drugs are prescribed to prevent a disease or condition or help you manage an existing issue. Value-Based Insurance Design (VBID) covers maintenance medication for members with some chronic conditions. You just pay the co-pay below.

If integrated, prescription (Rx) expenses contribute to overall maximum out-of-pocket as well as Rx maximum out-of-pocket.

The most individuals or families will pay for covered services per year.

The most individuals or families will pay for prescription drugs per year.

Doesn't apply to individual plans. With aggregate, you must meet the family amount before the plan pays benefits. With stacked, the plan pays benefits once you meet your individual or family amount. An embedded MOOP ensures that no individual pays more than $7,350 in out-of-pocket costs (a requirement for all qualified health plans).

Categories for the different types of care provided by the plans. Co-pay=$ you pay / Co-insurance=% you pay

Care that includes screenings, tests, and counseling to prevent you from getting sick or to detect health conditions early. For lists of preventive services, go to VermontHealthConnect.gov and click on 'Health Plans.'

Office visit with a primary care provider or mental health professional.

Office visit with a care provider who focuses on a specific area of medicine (e.g. dermatologist), as well as physical therapy, occupational therapy, and covered alternative treatment benefits.

A type of walk-in clinic open seven days a week that primarily treats injuries or illness requiring immediate care, but not serious enough to require an ER visit.

Cost of an ambulance in case of emergency.

Emergency services you get in an emergency room. ER co-pay/co-insurance is waived if you are admitted to hospital.

Includes: Inpatient (including surgery, ICU/NICU, maternity, skilled nursing facilities, mental health, and substance abuse); Outpatient (including ambulatory surgery centers); Radiology (MRI, CT, PET).

Different levels of prescription drug coverage offered by the plan.

"Generic" typically applies to prescription drugs that have the same active ingredient formulas as brand-name drugs.

"Preferred" and "Non-preferred" are set by each insurance carrier. To find how specific drugs are categorized, go to VermontHealthConnect.gov and click on "Health Plans" or call BCBSVT (800-247-2583) or MVP (844-865-0250). For an exact list of medications in each category, please refer to the carriers' drug lists at http://info.healthconnect.vermont.gov/healthplans#Rx.

This is a partial list. See additional benefits in each plan's Summary of Benefits and Coverage.

Included in the medical plan for children up to 21. Some services are subject to the medical deductible. See plan materials for details.

FINANCIAL HELP: APTC & CSR

If you buy health insurance on your own (not through your employer), you may qualify for financial help. For example, a family of four with an income of up to $98,400 may qualify for Advanced Premium Tax Credits (APTC) to help pay for premiums. A family of four with an income up to $73,800 may also qualify for lower out-of-pocket costs through Cost-Sharing Reductions (CSR). This means that instead of covering 70% of health care costs on average, the enhanced silver plan will cover between 73% and 94% of costs. You can use APTC to purchase a plan in any metal level, but you can only get CSR with silver plans. To see how your particular premiums and out-of-pocket costs might be reduced, see the Subsidy Estimator at VermontHealthConnect.gov or call 1-855-899-9600 (toll-free).

REMINDER

Once confirmed, plan selections cannot be changed until the next open enrollment period, unless someone in your household has a qualifying event, such as a birth, death or a new job. If your health coverage is cancelled due to non-payment, you may not be able to get coverage again until the following January.

[1] BCBSVT Standard Silver has a $300 Rx Deductible per person, while the Rx Deductible for MVP Standard Silver is $300 for a single plan or $600 for all other tiers.

[2] Combined 3/6/9 visits PCP/MH with no cost-share; then deductible applies with $30 co-pay.

[3] Costs may vary by service. Please consult your issuer's documents for complete details.

2018 Silver Plan Designs with Cost-Sharing Reductions

2018 Silver 73 Plans

Note: Silver 73 health plans are only available to Vermonters with qualifying incomes. To see if you qualify, visit the Plan Comparison Tool at https://vt.checkbookhealth.org or call 1-855-899-9600.

2018 Silver 73 Plans	Standard Silver 73	Silver 73 HDHP (can pair with HSA)		Blue Rewards Silver 73	MVP VT Plus Non-Standard Silver 73
		MVP	BCBSVT		
Deductible/Max. Out-of-Pocket	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family
Deductible (Ded.) Integrated Ded.?	N	Y - $1,550/ $3,100	Y - $1,550/ $3,100	Y - $2,100/ $4,200	N
Deductible (Ded.) Medical Ded.	$2,550/$5,100	See above	See above	See above	$1,100/$2,200
Deductible (Ded.) Waived[1] for: (see Services below)	Prev, OV, UC, Amb, Dent.[3]	Prev	Prev	Prev, Den1 3 PCP/MH OV	Prev, Den1 3 PCP/MH OV
Deductible (Ded.) Prescription (Rx) Ded.	$300/$600	N/A	N/A	N/A	$300/$600
Deductible (Ded.) Waived for:	Rx Generic	Rx Wellness[4]	Rx Wellness[4]	Not Waived	Not Waived
Max. Out-of-Pocket (MOOP) Integrated?	Y - $5,700/ $11,400	Y-$4,100/ $8,200	Y-$4,100/ $8,200	Y-$5,700/ $11,400	Y-$4,550/ $9,100
Max. Out-of-Pocket (MOOP) Medical	See above	See above	See above	See above	See above
Max. Out-of-Pocket (MOOP) Prescription (Rx)	$1,200/$2,400	$1,350/$2,700	$1,350/$2,700	$1,350/$2,700	$1,300/$2,600
Stacked, Embedded or Aggregate?[2]	Stacked[4]	Aggregate Embedded[5]	Aggregate Embedded[5]	Aggregate Embedded[5]	Stacked[4]
Service Category (Examples)	Co-insurance (%) / Co pay (s)	Co-insurance (%) / Co pay (s)	Co-insurance (%) / Co pay (s)	Co-insurance (%) / Co pay (s)	Co-insurance (%) / Co pay (s)
Preventive (Prev)	$0	$0	$0	$0	$0
Office Visit (OV) PCP or Mental Health (PCP/MH)	$25	Ded., then 10%	Ded., then 10%	3 visits per person (up to 9 per family) with no cost-share; then deductible applies with co-pay of $30	3 visits per person (up to 9 per family) with no cost-share; then deductible applies with co-pay of $30
Office Visit (OV) Specialist[3]	$65	Ded., then 25%	Ded., then 25%	Ded., then $50	Ded., then $60
Urgent Care (UC)	$75	'Ded., then 25%	'Ded., then 25%	Ded., then $50	Ded., then $60
Ambulance (Amb)	$100	'Ded., then 25%	'Ded., then 25%	Ded., then $50	Ded., then $100
Emergency Room (ER) [7]	Ded., then $250	'Ded., then 25%	'Ded., then 25%	Ded., then $400	Ded., then $350
Hospital Services[6] Inpatient	Ded., then 40%	'Ded., then 25%	'Ded., then 25%	Ded., then $1,500	Ded., then 50%
Hospital Services[6] Outpatient	Ded., then 40%	'Ded., then 25%	'Ded., then 25%	Ded., then $1,500	Ded., then $1,400
Prescription (Rx) Drug Coverage	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply
Rx Generic[5]	$12	Ded., then $10[8]	Ded., then $10[8]	Ded., then $5	Ded., then $5
Rx Preferred Brand[5]	Ded., then $60	Ded., then $40[8]	Ded., then $40[8]	Ded., then 40%	Ded., then 50%
Rx Non-Preferred Brand[5]	Ded., then 50%	Ded., then 50%	Ded., then 50%	Ded., then 60%	Ded., then 50%
Additional Benefits					
Wellness Benefits	N/A	N/A	N/A	Up to $300 in health & wellness rewards	N/A

2018 Silver 77 Plans

Note: Silver 77 health plans are only available to Vermonters with qualifying incomes. To see if you qualify, visit the Plan Comparison Tool at https://vt.checkbookhealth.org or call 1-855-899-9600.

2018 Silver 77 Plans	Standard Silver 77	Silver 77 HDHP (can pair with HSA)		Blue Rewards Silver 77	MVP VT Plus Non-Standard Silver 77
		MVP	BCBSVT		
Deductible/Max. Out-of-Pocket	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family
Deductible (Ded.) Integrated Ded.?	N	Y - $1,350/ $2,700	Y - $1,300/ $2,600	Y - $1,000/ $2,000	N
Deductible (Ded.) Medical Ded.	$2,000/$4,000	See above	See above	See above	$300/$600
Deductible (Ded.) Waived[1] for: (see Services below)	Prev, OV, UC, Amb, Dent.[3]	Prev	Prev	Prev, Den1 3 PCP/MH OV	Prev, Den1, 3 PCP/MH
Deductible (Ded.) Prescription (Rx) Ded.	$200/400[7]	N/A	N/A	N/A	$100/$200
Deductible (Ded.) Waived for:	Rx Generic	Rx Wellness[4]	Rx Wellness[4]	Not Waived	Not Waived
Max. Out-of-Pocket (MOOP) Integrated?	Y-$4,500/ $9,000	$3,000/$6,000	Y $3,000/ $6,000	Y-$5,200/ $10,400	N
Max. Out-of-Pocket (MOOP) Medical	See above	See above	See above	See above	$4,500/$9,000
Max. Out-of-Pocket (MOOP) Prescription (Rx)	$1,000/$2,000	Y-$1,350/ $2,700	Y-$1,350/ $2,700	$1,350/$2,700	$1,300/$2,600
Stacked, Embedded or Aggregate?[2]	Stacked[4]	Aggregate[5]	Aggregate[5]	Aggregate Embedded[5]	Stacked[4]
Service Category (Examples)	Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co pay ($)
Preventive (Prev)	$0	$0	$0	$0	$0
Office Visit (OV) PCP or Mental Health (PCP/MH)	$20	Ded., then 10%	Ded., then 10%	3 visits per person (up to 9 per family) with no cost-share; then deductible applies with co-pay of $30	3 visits per person (up to 9 per family) with no cost-share; then deductible applies with co-pay of $10
Office Visit (OV) Specialist[3]	$40	Ded., then 25%	Ded., then 25%	Ded., then $50	Ded., then $40
Urgent Care (UC)	$50	'Ded., then 25%	'Ded., then 25%	Ded., then $50	Ded., then $40
Ambulance (Amb)	$100	'Ded., then 25%	'Ded., then 25%	Ded., then $50	Ded., then $100
Emergency Room (ER) [7]	Ded., then $250	'Ded., then 25%	'Ded., then 25%	Ded., then $400	Ded., then $100
Hospital Services[6] Inpatient	Ded., then 40%	'Ded., then 25%	'Ded., then 25%	Ded., then $1,500	Ded., then 30%
Hospital Services[6] Outpatient	Ded., then 40%	'Ded., then 25%	'Ded., then 25%	Ded., then $1,500	Ded., then $800
Prescription (Rx) Drug Coverage	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply
Rx Generic[5]	$12	Ded., then $10[8]	Ded., then $10[8]	Ded., then $5	Ded., then $5
Rx Preferred Brand[5]	Ded., then $60	Ded., then $40[8]	Ded., then $40[8]	Ded., then 40%	Ded., then 40%
Rx Non-Preferred Brand[5]	Ded., then 50%	Ded., then 50%	Ded., then 50%	Ded., then 60%	Ded., then 40%
Additional Benefits					
Wellness Benefits	N/A	N/A	N/A	Up to $300 in health & wellness rewards	N/A

2018 Silver 87 Plans

Note: Silver 87 health plans are only available to Vermonters with qualifying incomes. To see if you qualify, visit the Plan Comparison Tool at https://vt.checkbookhealth.org or call 1-855-899-9600.

2018 Silver 87 Plans	Standard Silver 87	Silver 87 HDHP (cannot pair with HSA)		Blue Rewards Silver 87	MVP VT Plus Non-Standard Silver 87
		MVP	BCBSVT		
Deductible/Max. Out-of-Pocket	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family
Deductible (Ded.) Integrated Ded.?	N	Y - $1,200/ $2,400	Y -$1,200/ $2,400	Y - $200/$400	N
Deductible (Ded.) Medical Ded.	$800/$1,600	See above	See above	See above	$0
Deductible (Ded.) Waived[1] for: (see Services below)	Prev, OV, UC, Amb, Dent.[3]	Prev	Prev	Prev, Den1, 3 PCP/MH OV	Prev, Den1, PCP/MH OV
Deductible (Ded.) Prescription (Rx) Ded.	$150/$300[7]	N/A	N/A	N/A	N/A
Deductible (Ded.) Waived for:	Rx Generic	Not Waived	Rx Wellness[4]	Not Waived	N/A
Max. Out-of-Pocket (MOOP) Integrated?	Y - $1,600/ $3,200	Y-$1,200/ $2,400	Y-$1,200/ $2,400	Y-$2,000/ $4,000	N
Max. Out-of-Pocket (MOOP) Medical	See above	See above	See above	See above	$2,000/$4,000
Max. Out-of-Pocket (MOOP) Prescription (Rx)	$400/$800			$1,350/$2,700	$450/$900
Stacked, Embedded or Aggregate?[2]	Stacked[4]	Aggregate[5]	Aggregate[5]	Aggregate[5]	Stacked[4]
Service Category (Examples)	Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co pay ($)
Preventive (Prev)	$0	$0	$0	$0	$0
Office Visit (OV) PCP or Mental Health (PCP/MH)	$10	Ded., then $0	Ded., then $0	3 visits per person (up to 9 per family) with no cost-share; then deductible applies with co-pay of $30	$5
Office Visit (OV) Specialist[3]	$30	Ded., then $0	Ded., then $0	Ded., then $50	$30
Urgent Care (UC)	$40	Ded., then $0	Ded., then $0	Ded., then $50	$30
Ambulance (Amb)	$100	Ded., then $0	Ded., then $0	Ded., then $50	$50
Emergency Room (ER) [7]	Ded., then $250	Ded., then $0	Ded., then $0	Ded., then $250	$50
Hospital Services[6] Inpatient	Ded., then 40%	Ded., then $0	Ded., then $0	Ded., then $500	10%
Hospital Services[6] Outpatient	Ded., then 40%	Ded., then $0	Ded., then $0	Ded., then $500	$200
Prescription (Rx) Drug Coverage	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply
Rx Generic[5]	$10	Ded., then $0	Ded., then $0	Ded., then $5	$5
Rx Preferred Brand[5]	Ded., then $50	Ded., then $0	Ded., then $0	Ded., then 40%	20%
Rx Non-Preferred Brand[5]	Ded., then 50%	Ded., then $0	Ded., then $0	Ded., then 60%	40%
Additional Benefits					
Wellness Benefits	N/A	N/A	N/A	Up to $300 in health & wellness rewards	N/A

2018 Silver 94 Plans

Note: Silver 94 health plans are only available to Vermonters with qualifying incomes. To see if you qualify, visit the Plan Comparison Tool at https://vt.checkbookhealth.org or call 1-855-899-9600.

2018 Silver 94 Plans	Standard Silver 94	Silver 94 HDHP (cannot pair with HSA)		Blue Rewards Silver 94	MVP VT Plus Non-Standard Silver 94
		MVP	BCBSVT		
Deductible/Max. Out-of-Pocket	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family
Deductible (Ded.) Integrated Ded.?	N	Y - $550/ $1,100	Y - $550/ $1,100	Y - $0/$0	N
Deductible (Ded.) Medical Ded.	$150/$300	See above	See above	See above	$0
Deductible (Ded.) Waived[1] for: (see Services below)	Prev, OV, UC, Amb, Dent.[3]	Prev	Prev	$0 Deductible (see above)	$0 Deductible (see above)
Deductible (Ded.) Prescription (Rx) Ded.	$0	See above	See above	$0	$0
Deductible (Ded.) Waived for:	N/A	Not Waived	Rx Wellness[4]	N/A	N/A
Max. Out-of-Pocket (MOOP) Integrated?	Y - $800/ $1,600	Y-$550/ $1,100	Y-$550/ $1,100	Y-$950/ $1,900	N
Max. Out-of-Pocket (MOOP) Medical	See above	See above	See above	See above	$950/ $1,900
Max. Out-of-Pocket (MOOP) Prescription (Rx)	$200/$400			$950/$1,900	$150/$300
Stacked, Embedded or Aggregate?[2]	Stacked[4]	Aggregate[5]	Aggregate[5]	Aggregate[5]	Stacked[4]
Service Category (Examples)	Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co pay ($)
Preventive (Prev)	$0	$0	$0	$0	$0
Office Visit (OV) PCP or Mental Health (PCP/MH)	$5	Ded., then $0	Ded., then $0	3 visits per person (up to 9 per family) with no cost-share; then deductible applies with co-pay of $15	$5
Office Visit (OV) Specialist[3]	$15	Ded., then $0	Ded., then $0	$35	$10
Urgent Care (UC)	$25	Ded., then $0	Ded., then $0	$35	$10
Ambulance (Amb)	$50	Ded., then $0	Ded., then $0	$35	$25
Emergency Room (ER) [7]	Ded., then $75	Ded., then $0	Ded., then $0	$250	$25
Hospital Services[6] Inpatient	Ded., then 10%	Ded., then $0	Ded., then $0	$0	5%
Hospital Services[6] Outpatient	Ded., then 10%	Ded., then $0	Ded., then $0	$0	$40
Prescription (Rx) Drug Coverage	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply
Rx Generic[5]	$5	Ded., then $0	Ded., then $0	$5	$5
Rx Preferred Brand[5]	$20	Ded., Then $0	Ded., Then $0	40%	5%
Rx Non-Preferred Brand[5]	30%	Ded., then $0	Ded., then $0	60%	5%
Additional Benefits					
Wellness Benefits	N/A	N/A	N/A	Up to $300 in health & wellness rewards	N/A

Footnotes
1 Abbreviations — Ded: Deductible, Rx: Prescription Drugs, OV: Office Visits, UC: Urgent Care, Amb: Ambulance, Dent: Pediatric Dental Class 1 Series (as indicated by plan), VBID: Value-Based Insurance Design.
2 Specialists co-pay also applies to PT/OT/ST, vision, and any alternative medicine benefits, as appropriate.
3 Dental is for children only.
4 Hospital Services are inpatient (including surgery, ICU/NICU, maternity, IMF and MH/SA), Outpatient (including ambulatory surgery centers), and Radiology (MRI, CT, PET). This cost-sharing will also include physician and anesthesia costs, as appropriate.
5 Each insurance carrier classifies drugs according to its own formulary. To see if a specific drug qualifies for the Generic or Preferred co-pay, view the formularies at http://info.healthconnect.vermont.gov/healthplans or contact BCBSVT (800-247-2583) or MVP (844-865-0250).
6 With an aggregate family deductible, your family must meet the family deductible before the plan pays benefits. Some HDHP aggregate family deductibles have an embedded individual maximum out-of-pocket of $7,350 to prevent one individual from paying the full family maximum out-of-pocket. With a stacked deductible, the plan pays benefits once you meet either your individual deductible or your family deductible.
7 BCBSVT Standard Silver73 plans have a $300 Rx deductible, and Silver 77 plans have a $200 Rx deductible on brand drugs per person, while MVP Standard Silver73 plans have an Rx Deductible of $300 on brand drugs for a single plan or $600 for a family plan. BCBSVT Standard Silver87 plans have a $150 Rx Deductible on brand drugs per person, while MVP Standard Silver87 plans have an Rx Deductible of $150 on brand drugs for a single plan or $300 for the family plan.
8 Members who have met their deductible for the year do not have to pay the deductible for Wellness prescriptions. See the BCBSVT and MVP lists of Wellness drugs at http://info.healthconnect.vermont.gov/healthplans.
9 This plan includes deductible-waived vision care for qualifying children. See Summary of Benefits and Coverage for details: http://info.healthconnect.vermont.gov/healthplans#SBC.

Plan details — Different plans cover specific drugs and services in different ways. For specifics, contact BCBSVT (800-247-2583) or MVP (844-865-0250).

VT Rate Tier	Definition
Tier I - Single	One person - the subscriber (may be an adult or a child)
Tier II - Couple	Two persons who are married to each other or are in a civil union, according to the rules of Vermont
Tier III - Single Head of Household (Half) with One or More Child(ren)	One adult subscriber and one or more dependent child(ren), up to the age of 26
Tier IV - Family	Couple* with one or more dependent child(ren), up to the age of 26

NOTES:
- Children age 26 and over may be covered if deemed incapacitated dependents.
- Dependent children include: biological children, adopted children, step-children, and children for whom subscriber is legal guardian.
- Individual market spouse and/or dependents may enroll in their own unique health plans (e.g., dual enrolls in BCBSVT Gold and mom enrolls in MVP Bronze).

Vermont Household Income Thresholds for Advanced Premium Tax Credits (APTC), Vermont Premium Assistance (VPA), and Cost Sharing Reductions (CSR)

Eligibility for 2018 Benefits Determined Based on 2017 Federal Poverty Level (FPL)

Household Size	100% (for reference)	150%	200%	250%	300%	400%
Upper FPL% and annual income limits for		Silver 94 (94% AV) CSR Tier I	Silver 87 (87% AV) CSR Tier II	Silver 77 (77% AV) CSR Tier III	VPA & Silver 73 (73% AV) CSR Tier IV	APTC only
1	$12,060	$18,090	$24,120	$30,150	$36,180	$48,240
2	$16,240	$24,360	$32,480	$40,600	$48,720	$64,960
3	$20,420	$30,630	$40,840	$51,050	$61,260	$81,680
4	$24,600	$36,900	$49,200	$61,500	$73,800	$98,400
5	$28,780	$43,170	$57,560	$71,950	$86,340	$115,120
6	$32,960	$49,440	$65,920	$82,400	$98,880	$131,840
7	$37,140	$55,710	$74,280	$92,850	$111,420	$148,560
8	$41,320	$61,980	$82,640	$103,300	$123,960	$165,280
For each additional person add	$4,180	$6,270	$8,360	$10,450	$12,540	$16,720

*Household size = tax filer + spouse (even if they live apart) + tax filer's dependents. Married couples must file jointly to be eligible for APTC and CSR.

Important
Once confirmed, plan selections cannot be changed until the next open enrollment period, unless someone in your household has a qualifying event. If your health coverage is cancelled due to non-payment, you may not be able to get coverage again until the following January.

Updated 10/12/17

CPI-All Urban Consumers (Current Series)
Original Data Value

Series Id: CUUR0100SA0
Not Seasonally Adjusted
Series Title: All items in Northeast urban, all urban consumers, not
Area: Northeast
Item: All items
Base Period: 1982-84=100
Years: 2008 to 2018

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual	HALF1	HALF2
2008	224.325	225.213	226.926	228.133	230.089	232.649	234.545	233.788	232.841	230.837	227.236	225.091	229.306	227.889	230.723
2009	225.436	226.754	227.309	227.840	228.136	229.930	230.154	230.883	231.200	231.304	231.708	231.462	229.343	227.568	231.119
2010	232.294	232.382	233.188	233.615	234.130	233.834	233.885	234.150	234.027	234.671	235.094	235.141	233.868	233.241	234.495
2011	235.969	237.110	239.074	240.267	241.566	241.690	242.282	243.033	243.323	243.014	242.652	241.987	240.997	239.279	242.715
2012	242.879	243.850	245.125	245.850	245.709	245.201	244.984	246.252	247.409	247.564	247.097	246.456	245.698	244.769	246.627
2013	247.277	248.665	248.719	248.464	248.584	248.851	249.411	249.858	250.231	249.320	249.503	249.567	249.038	248.427	249.648
2014	251.045	251.233	252.413	252.506	253.598	253.555	253.833	253.185	253.154	252.730	251.781	250.519	252.463	252.392	252.534
2015	250.016	250.619	251.451	251.760	252.770	253.626	253.405	252.903	252.922	252.504	252.573	251.670	252.185	251.707	252.663
2016	251.739	252.250	252.854	254.270	255.023	255.471	255.386	255.545	256.085	256.605	256.541	256.427	254.850	253.601	256.098
2017	258.073	258.768	258.510	259.165	259.386	259.335	258.833	259.508	260.875	260.580	260.630	260.791	259.538	258.873	260.203
2018	262.188	263.260	263.556	264.669	265.840	265.950								264.244	

source: https://data.bls.gov/timeseries/CUUR0100SA0?amp%253bdata_tool=XGtable&output_view=data&include_graphs=true

VTNGSP	Total Gross Domestic Product for Vermont, Millions of Dollars, Annual, Not

Frequency: Annual

observation_date	VTNGSP
2012-01-01	28195
2013-01-01	28690
2014-01-01	29420
2015-01-01	30299
2016-01-01	31292
2017-01-01	32197

FRED Graph Observations
Federal Reserve Economic Data
Link: https://fred.stlouisfed.org
Help: https://fred.stlouisfed.org/help-faq
Economic Research Division
Federal Reserve Bank of St. Louis

Seasonally Adjusted