Category	CDHP Comprehensive	Vermont Freedom Plan (PPO)
Plan Type / Product Line	CDHP / CDHP Blue	PPO / VFP
Plan Year Period	07/01/2019 - 06/30/2020 All accumulators, such as deductibles, out-of-pocket limits and benefit limits apply to your Plan Year for all medical and prescription drug benefits.	07/01/2019 - 06/30/2020 All accumulators, such as deductibles, out-of-pocket limits and benefit limits apply to your Plan Year for all medical and prescription drug benefits.
Plan Deductible Type	If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.	If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Federal Reform Status	ACA Non-Grandfathered	ACA Non-Grandfathered
Prescription Drug Summary	Wellness Drugs: No charge	Pharmacy: $100 deductible per member, $15 co-payment/$30 co-payment/$45 co-payment
Additional Benefit Inclusions	Infertility Medications and Medical Dental Services	Infertility Medications and Medical Dental Services
Benefit Exclusions	Standard Benefit Exclusions apply.	Standard Benefit Exclusions apply.
What is the overall deductible?	$2,500 individual / $5,000 family. Co-insurance and co-payments do not apply to the deductible. This benefit combines your prescription drug and medical deductibles.	$1,000 individual / $2,000 family preferred provider. $2,000 individual / $4,000 family non-preferred provider. Co-insurance and co-payments do not apply to the deductible. The deductible for preferred and non-preferred providers is separate.
What is the out-of-pocket limit for this plan?	$2,500 individual / $5,000 family. Prescription drugs: $1,350 individual / $2,700 family.	Medical: $3,500 individual / $7,000 family preferred provider. $7,000 individual / $14,000 family non-preferred provider. Prescription drugs: $1,350 individual / $2,700 family. The out-of-pocket for preferred and non-preferred providers is separate. Medical and prescription drug out-of-pocket limits are separate.

Category		CDHP Comprehensive	Vermont Freedom Plan (PPO)	
		Participating Provider	Preferred Provider	Non-Preferred Provider
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge* for primary care physician and mental health / substance abuse	$25 co-payment per visit for primary care physician and mental health / substance abuse	30% co-insurance* for primary care physician and mental health / substance abuse
	Specialist visit	No charge*	$40 co-payment per visit	30% co-insurance*
If you have a test	Diagnostic test (x-ray, blood work)	No charge* for office-based and outpatient hospital	20% co-insurance* for office-based and outpatient hospital	30% co-insurance* for office-based and outpatient hospital
	Imaging (CT/PET scans, MRIs)	No charge*	20% co-insurance*	30% co-insurance*
If you need drugs to treat your illness, more information about prescription drug coverage is at http://www.bcbsvt.com/pharmacy drug-list	Generic drugs	No charge*	$100 deductible per member, then $15 co-payment / $30 co-payment	Not covered
	Preferred brand drugs	No charge*	$100 deductible per member, then $30 co-payment / $60 co-payment	Not covered
	Non-preferred brand drugs	No charge*	$100 deductible per member, then $45 co-payment / $90 co-payment	Not covered
	Wellness drugs	No charge	Same as any other prescription.	Not covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge*	20% co-insurance*	30% co-insurance*
	Physician/surgeon fees	No charge*	20% co-insurance*	30% co-insurance*
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge*	20% co-insurance*	30% co-insurance*
	Physician/surgeon fee	No charge*	20% co-insurance*	30% co-insurance*
If you are pregnant	Office Visits	No charge*	$25 co-payment (one co-payment covers all maternity office visits by one network provider)	30% co-insurance*
	Childbirth/delivery professional services	No charge*	20% co-insurance*	30% co-insurance*
If you are pregnant	Childbirth/delivery facility services	No charge*	20% co-insurance*	30% co-insurance*
If your child needs dental or eye care	Eye exam	$20 co-payment per child exam; $20 co-payment per adult exam	$20 co-payment per child exam; $20 co-payment per adult exam	We pay up to our allowed price less your $20 co-payment
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

This document summarizes your health care benefits on a Plan Year basis. Your subscriber contract defines the complete terms and conditions of your benefits in detail. Should any questions arise concerning your benefits, your subscriber contract governs.

*Deductible applies to these services.