The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.bcbsvt.com/comp_cert. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.bcbsvt.com/glossary or call (800) 255-4550 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$2,500 individual / $5,000 family.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount each plan year before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. Your plan year: 01/01/2019 through 12/31/2019.</td>
</tr>
<tr>
<td>Co-insurance and co-payments do not apply to the deductible. This benefit combines your prescription drug and medical deductibles.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes, preventive services</td>
<td>This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment or co-insurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No. There are no other specific deductibles.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$2,500 individual / $5,000 family.</td>
<td>The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.</td>
</tr>
<tr>
<td>Prescription drugs: $1,350 individual / $2,700 family.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

*Deductible applies to these services.

SNO/BPN: 1024361/
### Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Participating Provider (You will pay the least)</td>
<td>Non-Participating Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge* for primary care physician and mental health / substance abuse</td>
<td>No charge* for primary care physician and mental health / substance abuse</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge*</td>
<td>No charge*</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>No charge* for chiropractic care, nutritional counseling, outpatient physical, speech, and occupational therapy</td>
<td>No charge* for outpatient physical, speech, and occupational therapy; chiropractic care and nutritional counseling not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/Screening/Immunization</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge* for office-based and outpatient hospital</td>
<td>No charge* for office-based and outpatient hospital</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge*</td>
<td>No charge*</td>
</tr>
</tbody>
</table>

*Deductible applies to these services.

**SNO/BPN:** 1024361/
### Common Medical Event

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<td>Non-Participating Provider (You will pay the most)</td>
</tr>
</tbody>
</table>

#### If you need drugs to treat your illness or condition.

- **Generic drugs**: No charge*
  - Not covered
- **Preferred brand drugs**: No charge*
  - Not covered
- **Non-preferred brand drugs**: No charge*
  - Not covered
- **Wellness drugs**: No charge
  - Not covered

*More information about prescription drug coverage is at [www.bcbsvt.com/rxcenter](http://www.bcbsvt.com/rxcenter).*

#### If you have outpatient surgery

- **Facility fee (e.g., ambulatory surgery center)**: No charge*
  - No charge*
- **Physician/surgeon fees**: No charge*
  - No charge*

*Some services require prior approval.

#### If you need immediate medical attention

- **Emergency room care**: No charge* for facility and physician services
  - No charge* for facility and physician services
- **Emergency medical transportation**: No charge*
  - No charge*
- **Urgent care**: No charge*
  - No charge*

*Must meet emergency criteria.

#### If you have a hospital stay

- **Facility fee (e.g., hospital room)**: No charge*
  - No charge*
- **Physician/surgeon fee**: No charge*
  - No charge*

*Out-of-state inpatient care requires prior approval.*

#### If you need mental health, behavioral health, or substance abuse services

- **Outpatient services**: No charge*
  - No charge*
- **Inpatient services**: No charge*
  - No charge*

*Includes facility and physician fees. Requires prior approval.*

---

*Deductible applies to these services.

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**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office Visits</td>
<td>Participating Provider (You will pay the least)</td>
<td>Non-Participating Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge*</td>
<td>No charge*</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge*</td>
<td>No charge*</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>No charge*</td>
<td>No charge*</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge* inpatient; cardiac/pulmonary services no charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge* for inpatient services</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care (facility)</td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment (including supplies)</td>
<td>No charge*</td>
<td>No charge*</td>
</tr>
<tr>
<td></td>
<td>Hospice</td>
<td>No charge*</td>
<td>No charge*</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Eye exam</td>
<td>$20 co-payment per child exam; $20 co-payment per adult exam</td>
<td>We pay up to our allowed price less your $20 co-payment</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

*Deductible applies to these services.

SNO/BPN: 1024361/
Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.):

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

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.):

- Bariatric surgery
- Non-emergency care when traveling outside the U.S. (www.bcbsvt.com/coveragewhiletraveling)
- Chiropractic Care (requires prior approval after 12 visits)
- Private-duty nursing (covered up to 14 hours per plan year)
- Infertility Medications
- Routine eye care (one routine eye exam per child and adult member per calendar year)

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov. You may also contact the plan at (800) 247-2583. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call (800) 318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: (800) 255-4550.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
### About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, co-payments and co-insurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible: $2,500
- Specialist co-payment: $0
- Hospital (facility) co-payment: $0
- Other co-payment: $0

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost:** $12,700

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Peg would pay is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,500</td>
</tr>
<tr>
<td>Co-payments</td>
<td>$0</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60

---

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible: $2,500
- Specialist co-payment: $0
- Hospital (facility) co-payment: $0
- Other co-payment: $0

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost:** $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Joe would pay is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,500</td>
</tr>
<tr>
<td>Co-payments</td>
<td>$0</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60

---

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible: $2,500
- Specialist co-payment: $0
- Hospital (facility) co-payment: $0
- Other co-payment: $0

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost:** $1,900

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Mia would pay is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,930</td>
</tr>
<tr>
<td>Co-payments</td>
<td>$0</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

---

**The plan** would be responsible for the other costs of these EXAMPLE covered services. The prescription drug out-of-pocket limit might not be included in the above Coverage Examples.

---

**Standard Plan Name:** BCBS-CDHP-2500-2500-0%-AGG-x-x-x-x-x-x-ACA-LARG(MD30613) BCBSC-Rx-C0%-1350-W-0-0-0-2-x-P(RX33956) wBERACA CY 1024361
NOTICE: Discrimination is Against the Law

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BCBSVT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

BCBSVT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394
TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, email at the contacts above. If you need assistance, our civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/office/file/index.html.

For free language-assistance services, call (800) 247-2583.

ARABIC
للحصول على خدمات المساعدة اللغة الجامعية، اتصل على الرقم (800) 247-2583.

SPANISH
Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

FRENCH
Pour obtenir des services d’assistance linguistique gratuits, appelez le (800) 247-2583.

ITALIAN
Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

PORTUGUESE
Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN
Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

NEPALI
नयाँ: भाषायातील सहायता, तुम्ही (800) 247-2583 उपयोग करू सक्दै.

SERBIAN-CROATIAN (SERBIAN)
За безплатну услугу превод, позвовите на број (800) 247-2583.

THAI
สำหรับการให้บริการความช่วยเหลือภาษาพื้นเมือง โทร (800) 247-2583