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/nonstd-cdhp-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.

### Important Questions

| What is the overall deductible? | $3,000 individual plan / $6,000 family aggregate. Co-insurance and co-payments do not apply to the deductible. This benefit combines your prescription drug and medical deductibles. | 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. |
| Are there services covered before you meet your deductible? | Yes, preventive care, wellness drugs | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
| Are there other deductibles for specific services? | No. There are no other specific deductibles. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | $3,000 individual plan / $6,000 family aggregate. Prescription drugs: $1,350 individual plan / $2,700 family aggregate. Medical and prescription drug out-of-pocket limits are combined. | 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. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, adult vision care, adult dental services and health care this plan doesn’t cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| Will you pay less if you use a network provider? | Yes. See www.bcbsvt.com/findadoctor or call (800) 255-4550 for a list of network providers. | 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. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

*Deductible applies to these services.

SNO/BPN: 1023433/
**BCBSVT Blue Rewards Gold CDHP Plan**

$3,000 / $6,000 Deductible, 0% co-insurance  
Wellness Drugs: $5 co-payment / 40% co-insurance / 60% co-insurance  

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

---

**All co-payment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.**

<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>In-Network Provider</td>
<td>Out-of-Network Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
<td></td>
</tr>
<tr>
<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>Not covered</td>
<td>Some services require prior approval. For clarification on mental health services visit <a href="http://www.bcbsvt.com/mental-health-primary-care">www.bcbsvt.com/mental-health-primary-care</a>.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>No charge*</td>
<td>Not covered</td>
<td>Some services require prior approval.</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>No charge* for chiropractic care, nutritional counseling, outpatient physical, speech, and occupational therapy</td>
<td>Not covered</td>
<td>Some services require prior approval. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined. Nutritional counseling benefits are covered up to 3 visits. There is no limit on the number of nutritional counseling visits for treatment of diabetes.</td>
</tr>
<tr>
<td>Preventive care/Screening/Immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a>.</td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge* for office-based and outpatient hospital</td>
<td>Not covered</td>
<td>Some services require prior approval.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge*</td>
<td>Not covered</td>
<td>Most services require prior approval.</td>
</tr>
</tbody>
</table>

---

*Deductible applies to these services.*
### Common Medical Event

<table>
<thead>
<tr>
<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><strong>Generic drugs</strong></td>
<td>In-Network Provider (You will pay the least)</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
</tr>
<tr>
<td></td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Preferred brand drugs</strong></td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Non-preferred brand drugs</strong></td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Wellness drugs</strong></td>
<td>$5 co-payment per prescription generic, 40% co-insurance preferred, 60% co-insurance non-preferred</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Facility fee (e.g., ambulatory surgery center)</strong></td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Physician/surgeon fees</strong></td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Emergency room care</strong></td>
<td>No charge* for facility and physician services</td>
<td>No charge* for facility and physician services</td>
</tr>
<tr>
<td><strong>Emergency medical transportation</strong></td>
<td>No charge*</td>
<td>No charge*</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>No charge*</td>
<td>No charge*</td>
</tr>
<tr>
<td><strong>Facility fee (e.g., hospital room)</strong></td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Physician/surgeon fee</strong></td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Outpatient services</strong></td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Inpatient services</strong></td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

*Deductible applies to these services.

**Coverage Period Begins:** 01/01/2019

**Coverage For:** All **Plan Type:** EPO
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Office Visits</td>
<td>No charge*</td>
<td>Not covered</td>
<td>Cost sharing does not apply for preventive services. Depending on the type of services, a deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). For a list of services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a>.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge*</td>
<td>Not covered</td>
<td>Out-of-state inpatient care requires prior approval.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge*</td>
<td>Not covered</td>
<td>Out-of-state inpatient care requires prior approval.</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>No charge*</td>
<td>Not covered</td>
<td>Home infusion therapy requires prior approval. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge* inpatient; cardiac / pulmonary services no charge*</td>
<td>Not covered</td>
<td>Inpatient rehabilitation services require prior approval.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge* for inpatient services</td>
<td>Not covered</td>
<td>Requires prior approval. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care (facility)</td>
<td>No charge*</td>
<td>Not covered</td>
<td>Requires prior approval.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment (including supplies)</td>
<td>No charge*</td>
<td>Not covered</td>
<td>May require prior approval.</td>
</tr>
<tr>
<td></td>
<td>Hospice</td>
<td>No charge*</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

*Deductible applies to these services.

SNO/BPN: 1023433/
**Common Medical Event** | **Services You May Need** | **In-Network Provider (You will pay the least)** | **Out-of-Network Provider (You will pay the most)** | **Limitations, Exceptions & Other Important Information**
---|---|---|---|---
If your child needs dental or eye care

Eye exam

No charge* per child exam; 100% of charges for adult exam

Not covered

One routine exam per calendar year.

Glasses

No charge* for child glasses; 100% of charges for adult glasses

Not covered

One pair of exchange-level frames and lenses for prescription glasses or one pair of equivalent contact lenses per calendar year.

Dental check-up

Child: Class I: No charge*, Class II: No charge*, Class III: No charge*

Adult: 100% of charges

Not covered

Some services require prior approval. Deductible does not apply to Preventive fluoride supplements for children with non-fluoridated drinking water.

**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
- Routine eye care (age 21 and older)
- Cosmetic Surgery (except with prior approval for reconstruction)
- Infertility Medications
- Routine foot care (except for treatment of diabetes)
- Dental care (age 21 and older)
- Long-term care
- Weight loss programs

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

- Abortion
- Non-emergency care when traveling outside the U.S. (www.bcbsvt.com/coveragewhiletraveling)
- Bariatric surgery (requires prior approval)
- Private-duty nursing (covered up to 14 hours per plan year)
- Chiropractic Care (requires prior approval after 12 visits)

*Deductible applies to these services.

SNO/BPN: 1023433/
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.
### Coverage Examples

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

- **The plan's overall deductible**: $3,000
- **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
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

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

In this example, Peg would pay:

- **Cost Sharing**
  - **Deductibles**: $3,000
  - **Co-payments**: $0
  - **Co-insurance**: $0

**What isn't covered**
- **Limits or exclusions**: $60

The total Peg would pay is **$3,060**

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

- **The plan's overall deductible**: $3,000
- **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:

- **Cost Sharing**
  - **Deductibles**: $3,000
  - **Co-payments**: $0
  - **Co-insurance**: $0

**What isn't covered**
- **Limits or exclusions**: $60

The total Joe would pay is **$3,060**

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

- **The plan's overall deductible**: $3,000
- **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:

- **Cost Sharing**
  - **Deductibles**: $1,930
  - **Co-payments**: $0
  - **Co-insurance**: $0

**What isn't covered**
- **Limits or exclusions**: $0

The total Mia would pay is **$1,930**

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**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.

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**Custom Summary Name:** BCBS-EPO-CDHP-NONSTANDARD-GOLD-X-BASE-2019 (MD26593)_BCBS-RXHIX-0-1350-W-5-40%-60%-x-P(RX26688)_(13627VT0390001-01)  
**CY 1023433**
NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex.

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, or 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/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

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

ARABIC
للحصول على خدمات المساعدة
للغوية المجانية، 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.

JAPANESE
無料の通訳サービスのご利用は、(800) 247-2583 までお電話ください。

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

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

THAI
สำหรับการให้บริการความช่วยเหลือทางภาษา
โทร (800) 247-2583

TAJIK (Oromo)
Para sa libreng mga serbisyo ng tulong pangwi, tumawag sa (800) 247-2583.

VETERANS
Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.

CHINESE
如需免费语言援助服务，请致电
(800) 247-2583。

Oromo (Oromo)
Tajaujila gargaarsa afaan hiikuu kaffaltii malee argachuuf
(800) 247-2583 bilbila.