### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$1,550 individual / $3,100 family aggregate.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount each year before the 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>Are there services covered before you meet your deductible?</td>
<td>Yes, preventive care, dental class I, the first three primary care, mental health and substance abuse office visits (including routine lab services) combined up to a total of nine visits per family</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>$5,150 individual plan. Family plans have an individual out-of-pocket limit of $7,900 and $10,300 aggregate family. Prescription drugs: $1,350 individual plan / $2,700 family aggregate. Medical and prescription drug out-of-pocket limits are combined.</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>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, adult vision care, adult dental services 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.

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

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

**Coverage For:** All

**Plan Type:** EPO

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

**Coverage For:** All

**Plan Type:** EPO

For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.bcbsvt.com/nonstd-copay-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.
## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>In-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 co-payment* per visit for primary care physician and mental health / substance abuse</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$30 co-payment* per visit</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$30 co-payment* per visit for chiropractic care, nutritional counseling, outpatient physical, speech, and occupational therapy</td>
</tr>
<tr>
<td>Preventive care/Screening/Immunization</td>
<td>No charge</td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$30 co-payment* per visit for office-based and outpatient hospital</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$750 co-payment* per visit</td>
</tr>
</tbody>
</table>

### What You Will Pay

<table>
<thead>
<tr>
<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>Primary care visit to treat an injury or illness</td>
<td>$20 co-payment* per visit for primary care physician and mental health / substance abuse</td>
<td>Not covered</td>
<td>Some services require prior approval. Deductible and co-payments do not apply to some services see <a href="http://www.bcbsvt.com/nonstd-copays">www.bcbsvt.com/nonstd-copays</a> for more information. 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>$30 co-payment* per visit</td>
<td>Not covered</td>
<td>Some services require prior approval.</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$30 co-payment* per visit</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>$30 co-payment* per visit</td>
<td>Not covered</td>
<td>Some services require prior approval. Deductible and co-payments do not apply to some services see <a href="http://www.bcbsvt.com/nonstd-copays">www.bcbsvt.com/nonstd-copays</a> for more information.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$750 co-payment* per visit</td>
<td>Not covered</td>
<td>Most services require prior approval.</td>
</tr>
</tbody>
</table>

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

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

**Coverage For:** All

**Plan Type:** EPO

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*Deductible applies to these services.

**SNO/BPN:** 1023431/
## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered 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>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition. More information about prescription drug coverage is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a>. This plan follows the National Preferred Formulary (NPF).</td>
<td>Generic drugs</td>
<td>$5 co-payment* per prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>40% co-insurance*</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>60% co-insurance*</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Wellness drugs</td>
<td>Wellness prescription drugs process the same as any other prescription.</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$750 co-payment* per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$250 co-payment* per visit for facility services; no charge* for physician services</td>
<td>$250 co-payment* per visit for facility services; no charge* for physician services</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$30 co-payment* per member per day</td>
<td>$30 co-payment* per member per day</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$30 co-payment* per visit</td>
<td>$30 co-payment* per visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$750 co-payment* per admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$750 co-payment* per admission</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

*Deductible applies to these services.

**SNO/BPN:** 1023431/
<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>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office Visits</td>
<td>$20 co-payment* per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge*</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$750 co-payment* per admission</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>$30 co-payment* per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$750 co-payment* per inpatient admission; no charge* cardiac / pulmonary services</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$750 co-payment* per inpatient admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care (facility)</td>
<td>$750 co-payment* per admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment (including supplies)</td>
<td>$30 co-payment*</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice</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

Limitations, Exceptions & Other Important Information:
- Cost sharing does not apply for preventive services. Depending on the type of services, a co-payment, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). For a list of services visit www.bcbsvt.com/preventive.
- Out-of-state inpatient care requires prior approval.
- Home infusion therapy requires prior approval.
- Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.
- Inpatient rehabilitation services require prior approval.
- Requires prior approval. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.
- Requires prior approval.
- May require prior approval.
### 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:** 1023431/
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.
### The plan's overall deductible
- $1,550
- $30
- $750
- $750

### Specialist co-payment
- $30
- $750
- $750

### Hospital (facility) co-payment
- $750

### Other co-payment
- $750

---

**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)

**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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,550</td>
</tr>
<tr>
<td>Co-payments</td>
<td>$1,480</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

**The total Peg would pay is**

$3,090

---

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

**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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,550</td>
</tr>
<tr>
<td>Co-payments</td>
<td>$940</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$1,290</td>
</tr>
</tbody>
</table>

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

**The total Joe would pay is**

$3,840

---

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

**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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,550</td>
</tr>
<tr>
<td>Co-payments</td>
<td>$240</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

**The total Mia would pay is**

$1,790

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.
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@bebsvt.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.