

\$5,000 / \$10,000 Deductible, 50% co-insurance

Pharmacy: \$25 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/nonstd-cdhp-cert](http://www.bcbsvt.com/nonstd-cdhp-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$5,000 individual / \$10,000 family. Co-insurance and co-payments do not count towards the deductible. Deductible does not apply to preventive care and wellness drugs. This benefit combines your prescription drug and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$6,250 individual / \$12,500 family. Prescription drugs are limited to \$1,300 individual / \$2,600 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	50% co-insurance* for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	50% co-insurance*	Not covered	Some services require prior approval.
	Other practitioner office visit	50% co-insurance* for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	50% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	50% co-insurance*	Not covered	Most services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$25 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	40% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	60% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process according to the cost share listed above. This benefit excludes wellness prescription drugs from the deductible.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	50% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	50% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	50% co-insurance* for facility and physician services	50% co-insurance* for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	50% co-insurance*	50% co-insurance*	Must meet emergency criteria.
	Urgent care	50% co-insurance*	50% co-insurance*	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% co-insurance*	Not covered	None

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		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Physician / surgeon fee	50% co-insurance*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	50% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	50% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	50% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	50% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	50% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	50% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	50% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	50% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	50% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	50% co-insurance*	Not covered	May require prior approval.
	Hospice	50% co-insurance*	Not covered	None

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		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Eye exam	50% co-insurance* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	50% co-insurance* 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: 30% co-insurance*, Class III: 50% co-insurance* 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:**

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing aids</li> <li>• Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>• Infertility treatment</li> <li>• Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (age 21 and older)</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul>
<b>Other Covered Services</b> (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>• Bariatric surgery (requires prior approval)</li> <li>• Private-duty nursing (covered up to 14 hours per member per plan year)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care (requires prior approval after 12 visits)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S. (<a href="http://www.bcbsvt.com/coveragewhiletraveling">www.bcbsvt.com/coveragewhiletraveling</a>)</li> </ul>

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### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- **SPANISH (Español):** Para obtener asistencia en Español, llame al (800) 255-4550.
- **TAGALOG (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- **CHINESE (中文):** 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- **NAVAJO (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$2,280
- **Patient pays :** \$5,260

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$5,000
Co-pays	\$20
Coinsurance	\$90
Limits or exclusions	\$150
<b>Total</b>	<b>\$5,260</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$170
- **Patient pays :** \$5,230

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$5,000
Co-pays	\$80
Coinsurance	\$70
Limits or exclusions	\$80
<b>Total</b>	<b>\$5,230</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-CDHP-NONSTANDARD-BRONZE-X-BASE(MD15346) BCBS-RXHIX-0-1250-x-25-0.40-0.60-x-P(RX15344) CY 1014705

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Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$5,000 individual / \$10,000 family. Co-insurance and co-payments do not count towards the deductible. Deductible does not apply to preventive care and wellness drugs. This benefit combines your prescription drug and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$6,250 individual / \$12,500 family. Prescription drugs are limited to \$1,300 individual / \$2,600 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

#You will pay no cost share when you receive care from a provider that is an Indian Health Service or Indian Tribe, Tribal Organization, or Urban Indian Organization. **Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-cdhp-cert](http://www.bcbsvt.com/nonstd-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossar](http://www.bcbsvt.com/glossar) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

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**Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)

This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge	50% co-insurance* for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge	50% co-insurance*	Not covered	Some services require prior approval.
	Other practitioner office visit	No charge	50% co-insurance* for chiropractic care, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	No charge	50% co-insurance*	Not covered	Most services require prior approval.

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**SNO/BPN:** 1014704 /

\$5,000 / \$10,000 Deductible, 50% co-insurance

Pharmacy: \$25 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge	\$25 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge	40% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	No charge	60% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	No charge	Wellness prescription drugs process according to the cost share listed above. This benefit excludes wellness prescription drugs from the deductible.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% co-insurance*	Not covered	Some services require prior approval.
	Physician/surgeon fees	No charge	50% co-insurance*	Not covered	Some services require prior approval.

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**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency room services	No charge	50% co-insurance* for facility and physician services	50% co-insurance* for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	No charge	50% co-insurance*	50% co-insurance*	Must meet emergency criteria.
	Urgent care	No charge	50% co-insurance*	50% co-insurance*	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% co-insurance*	Not covered	None
	Physician/surgeon fee	No charge	50% co-insurance*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	50% co-insurance*	Not covered	Some services require prior approval.
	Mental/Behavioral health inpatient services	No charge	50% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge	50% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge	50% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	No charge	Not covered	None
	Delivery and all inpatient services	No charge	50% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	50% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge	50% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Habilitation services	No charge	50% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	No charge	50% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	No charge	50% co-insurance*	Not covered	May require prior approval.
	Hospice	No charge	50% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	No charge	50% co-insurance* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	No charge	50% co-insurance* 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	No charge	Child: Class I: No charge*, Class II: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover** (This isn't a complete list. Check the policy or plan document for other [excluded services](#).)

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

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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SNO/BPN: 1014704 /

\$5,000 / \$10,000 Deductible, 50% co-insurance

Pharmacy: \$25 co-payment / 40% co-insurance / 60% co-insurance

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$2,280
- **Patient pays :** \$5,260

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$5,000
Co-pays	\$20
Coinsurance	\$90
Limits or exclusions	\$150
<b>Total</b>	<b>\$5,260</b>

**Managing type 2 diabetes**  
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$170
- **Patient pays :** \$5,230

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$5,000
Co-pays	\$80
Coinsurance	\$70
Limits or exclusions	\$80
<b>Total</b>	<b>\$5,230</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-CDHP-NONSTANDARD-BRONZE-NA-BASE(MD15370) BCBS-RxHIXNativeAmerican-0-1250-x-25-0.40-0.60-x-P(RX15398) CY 1014704

**Template Name :** MedHIX-NativeAmerican-3-Network-012015

\$2,000 / \$4,000 Deductible, 50% co-insurance

Pharmacy: \$12 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$2,000 individual / \$4,000 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care or wellness drugs. This benefit combines your prescription and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$6,250 individual / \$12,500 family. Prescription drugs are limited to \$1,300 individual / \$2,600 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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\$2,000 / \$4,000 Deductible, 50% co-insurance

Pharmacy: \$12 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	50% co-insurance* for primary care physician and mental health / substance abuse	Not covered	Some services require prior approval. 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> .
	Specialist visit	50% co-insurance*	Not covered	Some services require prior approval.
	Other practitioner office visit	50% co-insurance* for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	50% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval. Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	50% co-insurance*	Not covered	Most services require prior approval.

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**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$12 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	40% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	60% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process according to the cost share listed above. This benefit excludes wellness prescription drugs from the deductible.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	50% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	50% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	50% co-insurance* for facility and physician services	50% co-insurance* for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	50% co-insurance*	50% co-insurance*	Must meet emergency criteria.
	Urgent care	50% co-insurance*	50% co-insurance*	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% co-insurance*	Not covered	None

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**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Physician / surgeon fee	50% co-insurance*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	50% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	50% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	50% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	50% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	50% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	50% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	50% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	50% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	50% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	50% co-insurance*	Not covered	May require prior approval.
	Hospice	50% co-insurance*	Not covered	None

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\$2,000 / \$4,000 Deductible, 50% co-insurance  
 Pharmacy: \$12 co-payment / 40% co-insurance / 60% co-insurance

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Eye exam	50% co-insurance* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	50% co-insurance* 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: 30% co-insurance*, Class III: 50% co-insurance* 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:**

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing aids</li> <li>• Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>• Infertility treatment</li> <li>• Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (age 21 and older)</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul>
<b>Other Covered Services</b> (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>• Bariatric surgery (requires prior approval)</li> <li>• Private-duty nursing (covered up to 14 hours per member per plan year)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care (requires prior approval after 12 visits)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S. (<a href="http://www.bcbsvt.com/coveragewhiletraveling">www.bcbsvt.com/coveragewhiletraveling</a>)</li> </ul>

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**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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- **CHINESE (中文):** 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- **NAVAJO (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$3,780
- **Patient pays :** \$3,760

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$2,000
Co-pays	\$20
Coinsurance	\$1,590
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,760</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$2,310
- **Patient pays :** \$3,090

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$2,000
Co-pays	\$350
Coinsurance	\$660
Limits or exclusions	\$80
<b>Total</b>	<b>\$3,090</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-CDHP-STANDARD-BRONZE-X-BASE(MD15341) BCBS-RxHIX-0-1250-x-12-0.40-0.60-x-P(RX15342) CY 1014707

\$2,000 / \$4,000 Deductible, 50% co-insurance

Pharmacy: \$12 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$2,000 individual / \$4,000 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care or wellness drugs. This benefit combines your prescription and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$6,250 individual / \$12,500 family. Prescription drugs are limited to \$1,300 individual / \$2,600 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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**Coverage Period Begins: 01/01/2015**  
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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**



**Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.

**Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)

This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge	50% co-insurance* for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge	50% co-insurance*	Not covered	Some services require prior approval.
	Other practitioner office visit	No charge	50% co-insurance* for chiropractic care, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	No charge	50% co-insurance*	Not covered	Most services require prior approval.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge	\$12 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge	40% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	No charge	60% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	No charge	Wellness prescription drugs process according to the cost share listed above. This benefit excludes wellness prescription drugs from the deductible.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% co-insurance*	Not covered	Some services require prior approval.
	Physician/surgeon fees	No charge	50% co-insurance*	Not covered	Some services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency room services	No charge	50% co-insurance* for facility and physician services	50% co-insurance* for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	No charge	50% co-insurance*	50% co-insurance*	Must meet emergency criteria.
	Urgent care	No charge	50% co-insurance*	50% co-insurance*	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% co-insurance*	Not covered	None
	Physician/surgeon fee	No charge	50% co-insurance*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	50% co-insurance*	Not covered	Some services require prior approval.
	Mental/Behavioral health inpatient services	No charge	50% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge	50% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge	50% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	No charge	Not covered	None
	Delivery and all inpatient services	No charge	50% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	50% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge	50% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.

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Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Habilitation services	No charge	50% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	No charge	50% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	No charge	50% co-insurance*	Not covered	May require prior approval.
	Hospice	No charge	50% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	No charge	50% co-insurance* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	No charge	50% co-insurance* 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	No charge	Child: Class I: No charge*, Class II: 30% co-insurance*, Class III: 50% co-insurance* 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:**

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing aids</li> <li>• Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>• Infertility treatment</li> <li>• Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (age 21 and older)</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul>

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**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

#You will pay no cost share when you receive care from a provider that is an Indian Health Service or Indian Tribe, Tribal Organization, or Urban Indian Organization. **Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these **services**.

SNO/BPN: 1014706 /

\$2,000 / \$4,000 Deductible, 50% co-insurance

Pharmacy: \$12 co-payment / 40% co-insurance / 60% co-insurance

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$3,780
- **Patient pays :** \$3,760

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$2,000
Co-pays	\$20
Coinsurance	\$1,590
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,760</b>

**Managing type 2 diabetes**  
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$2,310
- **Patient pays :** \$3,090

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$2,000
Co-pays	\$350
Coinsurance	\$660
Limits or exclusions	\$80
<b>Total</b>	<b>\$3,090</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-CDHP-STANDARD-BRONZE-NA-BASE(MD15365) BCBS-RxHIXNativeAmerican-0-1250-x-12-0.40-0.60-x-P(RX15396) CY 1014706

\$1,550 / \$3,100 Deductible, 20% co-insurance

Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$1,550 individual / \$3,100 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care or wellness drugs. This benefit combines your prescription and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$5,750 individual / \$11,500 family. Prescription drugs are limited to \$1,300 individual / \$2,600 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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**SNO/BPN:** 1014708 /

\$1,550 / \$3,100 Deductible, 20% co-insurance

Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.

**Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)

This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge	10% co-insurance* for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge	20% co-insurance*	Not covered	Some services require prior approval.
	Other practitioner office visit	No charge	20% co-insurance* for chiropractic care, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	No charge	20% co-insurance*	Not covered	Most services require prior approval.

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\$1,550 / \$3,100 Deductible, 20% co-insurance

Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge	\$10 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge	\$40 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	No charge	50% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	No charge	Wellness prescription drugs process according to the cost share listed above. This benefit excludes wellness prescription drugs from the deductible.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% co-insurance*	Not covered	Some services require prior approval.
	Physician/surgeon fees	No charge	20% co-insurance*	Not covered	Some services require prior approval.

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\$1,550 / \$3,100 Deductible, 20% co-insurance

Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency room services	No charge	20% co-insurance* for facility and physician services	20% co-insurance* for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	No charge	20% co-insurance*	20% co-insurance*	Must meet emergency criteria.
	Urgent care	No charge	20% co-insurance*	20% co-insurance*	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% co-insurance*	Not covered	None
	Physician/surgeon fee	No charge	20% co-insurance*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	20% co-insurance*	Not covered	Some services require prior approval.
	Mental/Behavioral health inpatient services	No charge	20% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge	20% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge	20% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	No charge	Not covered	None
	Delivery and all inpatient services	No charge	20% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	20% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge	20% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Habilitation services	No charge	20% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	No charge	20% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	No charge	20% co-insurance*	Not covered	May require prior approval.
	Hospice	No charge	20% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	No charge	20% co-insurance* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	No charge	20% co-insurance* 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	No charge	Child: Class I: No charge*, Class II: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

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Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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SNO/BPN: 1014708 /

\$1,550 / \$3,100 Deductible, 20% co-insurance

Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$5,100
- **Patient pays :** \$2,440

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$1,550
Co-pays	\$20
Coinsurance	\$720
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,440</b>

**Managing type 2 diabetes**  
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$3,150
- **Patient pays :** \$2,250

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$1,550
Co-pays	\$330
Coinsurance	\$290
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,250</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

**Standard Plan Name:** BCBS-EPO-CDHP-STANDARD-SILVER-NA-BASE(MD15364) BCBS-RxHIXNativeAmerican-0-1300-x-10-40-0.50-x-P(RX15395) CY 1014708

\$1,400 / \$2,800 Deductible, 20% co-insurance  
 Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$1,400 individual / \$2,800 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care or wellness drugs. This benefit combines your prescription and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$3,400 individual / \$6,800 family. Prescription drugs are limited to \$1,300 individual / \$2,600 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$1,400 / \$2,800 Deductible, 20% co-insurance

Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	10% co-insurance* for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	20% co-insurance*	Not covered	Some services require prior approval.
	Other practitioner office visit	20% co-insurance* for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	20% co-insurance*	Not covered	Most services require prior approval.

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Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$10 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	\$40 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	50% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process according to the cost share listed above. This benefit excludes wellness prescription drugs from the deductible.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	20% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	20% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	20% co-insurance* for facility and physician services	20% co-insurance* for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	20% co-insurance*	20% co-insurance*	Must meet emergency criteria.
	Urgent care	20% co-insurance*	20% co-insurance*	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance*	Not covered	None

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\$1,400 / \$2,800 Deductible, 20% co-insurance

Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Physician / surgeon fee	20% co-insurance*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	20% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	20% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	20% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	20% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	20% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	20% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	20% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	20% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	20% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	20% co-insurance*	Not covered	May require prior approval.
	Hospice	20% co-insurance*	Not covered	None

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\$1,400 / \$2,800 Deductible, 20% co-insurance  
 Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Eye exam	20% co-insurance* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	20% co-insurance* 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: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover** (This isn't a complete list. Check the policy or plan document for other [excluded services](#).)

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

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- **SPANISH (Español):** Para obtener asistencia en Español, llame al (800) 255-4550.
- **TAGALOG (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- **CHINESE (中文):** 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- **NAVAJO (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

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 Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Coverage Period Begins: 01/01/2014**  
**Coverage For: All Plan Type: EPO**

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$5,220
- **Patient pays :** \$2,320

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$1,400
Co-pays	\$20
Coinsurance	\$750
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,320</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$3,260
- **Patient pays :** \$2,140

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$1,400
Co-pays	\$350
Coinsurance	\$310
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,140</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

**Standard Plan Name:** BCBS-EPO-CDHP-STANDARD-SILVER-X-73AV(MD15350) BCBS-RxHIX-0-1300-x-10-40-0.50-x-P(RX15341) CY 1014709

\$1,300 / \$2,600 Deductible, 20% co-insurance

Pharmacy: \$5 co-payment / \$30 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



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Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$1,300 individual / \$2,600 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care or wellness drugs. This benefit combines your prescription and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$2,500 individual / \$5,000 family. Prescription drugs are limited to \$1,300 individual / \$2,600 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$1,300 / \$2,600 Deductible, 20% co-insurance

Pharmacy: \$5 co-payment / \$30 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	10% co-insurance* for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	20% co-insurance*	Not covered	Some services require prior approval.
	Other practitioner office visit	20% co-insurance* for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	20% co-insurance*	Not covered	Most services require prior approval.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$1,300 / \$2,600 Deductible, 20% co-insurance

Pharmacy: \$5 co-payment / \$30 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$5 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	\$30 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	50% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription. This benefit excludes wellness prescription drugs from the deductible.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	20% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	20% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	20% co-insurance* for facility and physician services	20% co-insurance* for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	20% co-insurance*	20% co-insurance*	Must meet emergency criteria.
	Urgent care	20% co-insurance*	20% co-insurance*	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance*	Not covered	None

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\$1,300 / \$2,600 Deductible, 20% co-insurance

Pharmacy: \$5 co-payment / \$30 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Physician / surgeon fee	20% co-insurance*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	20% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	20% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	20% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	20% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	20% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	20% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	20% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	20% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	20% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	20% co-insurance*	Not covered	May require prior approval.
	Hospice	20% co-insurance*	Not covered	None

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\$1,300 / \$2,600 Deductible, 20% co-insurance

Pharmacy: \$5 co-payment / \$30 co-payment / 50% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Eye exam	20% co-insurance* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	20% co-insurance* 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: 30% co-insurance*, Class III: 50% co-insurance* 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:

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing aids</li> <li>• Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>• Infertility treatment</li> <li>• Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (age 21 and older)</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul>
<b>Other Covered Services</b> (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>• Bariatric surgery (requires prior approval)</li> <li>• Private-duty nursing (covered up to 14 hours per member per plan year)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care (requires prior approval after 12 visits)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S. (<a href="http://www.bcbsvt.com/coveragewhiletraveling">www.bcbsvt.com/coveragewhiletraveling</a>)</li> </ul>

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$1,300 / \$2,600 Deductible, 20% co-insurance

Pharmacy: \$5 co-payment / \$30 co-payment / 50% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- **SPANISH (Español):** Para obtener asistencia en Español, llame al (800) 255-4550.
- **TAGALOG (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- **CHINESE (中文):** 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- **NAVAJO (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$1,250 / \$2,500 Deductible, 20% co-insurance  
 Pharmacy: \$5 co-payment / \$30 co-payment / 50% co-insurance

**Coverage Period Begins: 01/01/2014**  
**Coverage For: All Plan Type: EPO**

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$5,350
- **Patient pays :** \$2,190

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$1,250
Co-pays	\$10
Coinsurance	\$780
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,190</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$3,580
- **Patient pays :** \$1,820

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$1,250
Co-pays	\$180
Coinsurance	\$310
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,820</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-CDHP-STANDARD-SILVER-X-77AV(MD15372) BCBS-RxHIX-0-1300-x-5-30-0.5-x-P(RX15351) CY 1014710

\$1,000 / \$2,000 Deductible

Wellness Drugs: No charge

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$1,000 individual / \$2,000 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care or wellness drugs. This benefit combines your prescription and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$1,000 individual / \$2,000 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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\$1,000 / \$2,000 Deductible

Wellness Drugs: No charge

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge* for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge*	Not covered	Some services require prior approval.
	Other practitioner office visit	No charge* for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	No charge*	Not covered	Most services require prior approval.

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\$1,000 / \$2,000 Deductible

Wellness Drugs: No charge

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	No charge*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process according to the cost share listed above. This benefit excludes wellness prescription drugs from the deductible.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	No charge*	Not covered	Some services require prior approval.
	Physician / surgeon fees	No charge*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	No charge* for facility and physician services	No charge* for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	No charge*	No charge*	Must meet emergency criteria.
	Urgent care	No charge*	No charge*	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge*	Not covered	None
	Physician / surgeon fee	No charge*	Not covered	Some services require prior approval.

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\$1,000 / \$2,000 Deductible

Wellness Drugs: No charge

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	No charge*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	No charge*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	No charge*	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	No charge* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	No charge*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	No charge*	Not covered	May require prior approval.
	Hospice	No charge*	Not covered	None
If you or your child needs dental or eye care	Eye exam	No charge* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$1,000 / \$2,000 Deductible

Wellness Drugs: No charge

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	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: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)		
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\$1,000 / \$2,000 Deductible

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

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### Your Grievance and Appeals Rights:

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The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

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\$1,000 / \$2,000 Deductible  
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**Coverage Period Begins: 01/01/2014**  
**Coverage For: All Plan Type: EPO**

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



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Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$6,390
- **Patient pays :** \$1,150

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$1,000
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,150</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$4,320
- **Patient pays :** \$1,080

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$1,000
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,080</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-CDHP-STANDARD-SILVER-X-87AV(MD15351) BCBS-RxHIX-C0%-X-W-0-0-2-x-P(RX16181) CY 1014711

\$450 / \$900 Deductible

Wellness Drugs: No charge

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$450 per individual / \$900 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care or wellness drugs. This benefit combines your prescription and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$450 individual / \$900 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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\$450 / \$900 Deductible

Wellness Drugs: No charge

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge* for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge*	Not covered	Some services require prior approval.
	Other practitioner office visit	No charge* for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	No charge*	Not covered	Most services require prior approval.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	No charge*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process according to the cost share listed above. This benefit excludes wellness prescription drugs from the deductible.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	No charge*	Not covered	Some services require prior approval.
	Physician / surgeon fees	No charge*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	No charge* for facility and physician services	No charge* for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	No charge*	No charge*	Must meet emergency criteria.
	Urgent care	No charge*	No charge*	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge*	Not covered	None
	Physician / surgeon fee	No charge*	Not covered	Some services require prior approval.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
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**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	No charge*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	No charge*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	No charge*	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	No charge* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	No charge*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	No charge*	Not covered	May require prior approval.
	Hospice	No charge*	Not covered	None
If you or your child needs dental or eye care	Eye exam	No charge* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	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: 30% co-insurance*, Class III: 50% co-insurance* 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.

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<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
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- **CHINESE (中文):** 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- **NAVAJO (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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\$450 / \$900 Deductible  
 Wellness Drugs: No charge

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Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$6,940
- **Patient pays :** \$600

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$450
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$600</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$4,870
- **Patient pays :** \$530

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$450
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$530</b>

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-CDHP-STANDARD-SILVER-X-94AV(MD15352) BCBS-RxHIX-C0%-X-W-0-0-0-2-x-P(RX16181) CY 1014712

\$1,550 / \$3,100 Deductible, 20% co-insurance  
 Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$1,550 individual / \$3,100 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care or wellness drugs. This benefit combines your prescription and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$5,750 individual / \$11,500 family. Prescription drugs are limited to \$1,300 individual / \$2,600 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$1,550 / \$3,100 Deductible, 20% co-insurance  
 Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	10% co-insurance* for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	20% co-insurance*	Not covered	Some services require prior approval.
	Other practitioner office visit	20% co-insurance* for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	20% co-insurance*	Not covered	Most services require prior approval.

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\$1,550 / \$3,100 Deductible, 20% co-insurance

Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$10 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	\$40 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	50% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process according to the cost share listed above. This benefit excludes wellness prescription drugs from the deductible.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	20% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	20% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	20% co-insurance* for facility and physician services	20% co-insurance* for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	20% co-insurance*	20% co-insurance*	Must meet emergency criteria.
	Urgent care	20% co-insurance*	20% co-insurance*	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance*	Not covered	None

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\$1,550 / \$3,100 Deductible, 20% co-insurance

Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Physician / surgeon fee	20% co-insurance*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	20% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	20% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	20% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	20% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	20% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	20% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	20% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	20% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	20% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	20% co-insurance*	Not covered	May require prior approval.
	Hospice	20% co-insurance*	Not covered	None

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\$1,550 / \$3,100 Deductible, 20% co-insurance  
 Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Eye exam	20% co-insurance* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	20% co-insurance* 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: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover** (This isn't a complete list. Check the policy or plan document for other [excluded services](#).)

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

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

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\$1,550 / \$3,100 Deductible, 20% co-insurance

Pharmacy: \$10 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- **SPANISH (Español):** Para obtener asistencia en Español, llame al (800) 255-4550.
- **TAGALOG (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- **CHINESE (中文):** 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- **NAVAJO (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$5,100
- **Patient pays :** \$2,440

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$1,550
Co-pays	\$20
Coinsurance	\$720
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,440</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$3,150
- **Patient pays :** \$2,250

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$1,550
Co-pays	\$330
Coinsurance	\$290
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,250</b>

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cdhp-cert](http://www.bcbsvt.com/standard-cdhp-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

**Standard Plan Name:** BCBS-EPO-CDHP-STANDARD-SILVER-X-BASE(MD15340) BCBS-RxHIX-0-1300-x-10-40-0.50-x-P(RX15341) CY 1014713



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$3,500 individual / \$7,000 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, prescription drugs or dental class I.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	Yes. \$300 prescription drug deductible per member.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$6,350 individual / \$12,700 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$35 PCP / \$80 Specialist co-payment, \$3,500 / \$7,000 Deductible

Pharmacy: \$20 co-payment / \$80 co-payment / 60% co-insurance, \$300 Rx Deductible

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$35 co-payment* per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	\$80 co-payment* per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	\$80 co-payment* per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	50% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	50% co-insurance*	Not covered	Most services require prior approval.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$300 deductible, then \$20 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	\$300 deductible, then \$80 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	\$300 deductible, then 60% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	50% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	50% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	50% co-insurance* for facility and physician services	50% co-insurance* for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	\$100 co-payment* per member per day	\$100 co-payment* per member per day	Must meet emergency criteria.
	Urgent care	\$100 co-payment* per visit	\$100 co-payment* per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% co-insurance*	Not covered	None
	Physician / surgeon fee	50% co-insurance*	Not covered	Some services require prior approval.

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\$35 PCP / \$80 Specialist co-payment, \$3,500 / \$7,000 Deductible

Pharmacy: \$20 co-payment / \$80 co-payment / 60% co-insurance, \$300 Rx Deductible

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	50% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	50% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	50% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	50% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	50% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	50% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	50% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	50% co-insurance* per inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	50% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	50% co-insurance*	Not covered	May require prior approval.
	Hospice	50% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	\$80 co-payment* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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\$35 PCP / \$80 Specialist co-payment, \$3,500 / \$7,000 Deductible  
 Pharmacy: \$20 co-payment / \$80 co-payment / 60% co-insurance, \$300 Rx Deductible  
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	\$80 co-payment* 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: 30% co-insurance*, Class III: 50% co-insurance* 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:**

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing aids</li> <li>• Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>• Infertility treatment</li> <li>• Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (age 21 and older)</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul>

<b>Other Covered Services</b> (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>• Bariatric surgery (requires prior approval)</li> <li>• Private-duty nursing (covered up to 14 hours per member per plan year)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care (requires prior approval after 12 visits)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S. (<a href="http://www.bcbsvt.com/coveragewhiletraveling">www.bcbsvt.com/coveragewhiletraveling</a>)</li> </ul>

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$35 PCP / \$80 Specialist co-payment, \$3,500 / \$7,000 Deductible

Pharmacy: \$20 co-payment / \$80 co-payment / 60% co-insurance, \$300 Rx Deductible

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- **SPANISH (Español):** Para obtener asistencia en Español, llame al (800) 255-4550.
- **TAGALOG (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- **CHINESE (中文):** 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- **NAVAJO (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$3,030
- **Patient pays :** \$4,510

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$3,520
Co-pays	\$0
Coinsurance	\$840
Limits or exclusions	\$150
<b>Total</b>	<b>\$4,510</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$1,920
- **Patient pays :** \$3,480

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$2,620
Co-pays	\$780
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$3,480</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-STANDARD-BRONZE-X-BASE(MD15339) BCBS-RxHIX-300-1250-x-20-80-0.60-x-P(RX15340) CY 1014723

\$6,660 / \$13,200 Deductible, 0% co-insurance

Pharmacy: Deductible, then no charge

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	<p>\$6,600 individual / \$13,200 family. Co-insurance and co-payments do not count towards the deductible. Deductible and co-payments do not apply to preventive care or the first three primary care, mental health and substance abuse office visits combined up to a total of nine visits per family. This benefit combines your prescription drug and medical deductibles.</p> <p>*Deductible applies to these services.</p>	<p>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.</p>
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$6,600 individual / \$13,200 family. Prescription drugs are limited to \$1,300 individual / \$2,600 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.

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\$6,660 / \$13,200 Deductible, 0% co-insurance

Pharmacy: Deductible, then no charge

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Important Questions	Answers	Why this matters:
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge* for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge*	Not covered	Some services require prior approval.
	Other practitioner office visit	No charge* for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge* for office-based and outpatient hospital	Not covered	Some services require prior approval.

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\$6,660 / \$13,200 Deductible, 0% co-insurance

Pharmacy: Deductible, then no charge

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a test	Imaging (CT/PET scans, MRIs)	No charge*	Not covered	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	No charge*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	No charge*	Not covered	Some services require prior approval.
	Physician / surgeon fees	No charge*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	No charge* for facility and physician services	No charge* for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	No charge*	No charge*	Must meet emergency criteria.
	Urgent care	No charge*	No charge*	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge*	Not covered	None
	Physician / surgeon fee	No charge*	Not covered	Some services require prior approval.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$6,660 / \$13,200 Deductible, 0% co-insurance

Pharmacy: Deductible, then no charge

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	No charge*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	No charge*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	No charge*	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	No charge* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	No charge*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	No charge*	Not covered	May require prior approval.
	Hospice	No charge*	Not covered	None
If you or your child needs dental or eye care	Eye exam	No charge* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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\$6,660 / \$13,200 Deductible, 0% co-insurance

Pharmacy: Deductible, then no charge

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	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: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover** (This isn't a complete list. Check the policy or plan document for other [excluded services](#).)

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

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

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Pharmacy: Deductible, then no charge

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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\$6,350 / \$12,700 Deductible, 0% co-insurance

Pharmacy: No charge / No charge / No charge

**Coverage Examples**

**Coverage Period Begins: 01/01/2014**

**Coverage For: All Plan Type: EPO**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$2,190
- **Patient pays :** \$5,350

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$5,200
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$5,350</b>

**Managing type 2 diabetes**  
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$50
- **Patient pays :** \$5,350

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$5,270
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$5,350</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-STANDARD-CAT-X-CAT(MD15359) BCBS-RxHIX-0-1300-x-0-0-0-x-P(RX15350) CY 1014724

\$15 PCP / \$25 Specialist co-payment, \$750 / \$1,500 Deductible

Pharmacy: \$5 co-payment / \$40 co-payment / 50% co-insurance; \$50 Rx Deductible (waived for Generics)

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$750 individual / \$1,500 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, emergency services, or prescription drugs.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	Yes. \$50 prescription drug deductible per member. Does not apply to generic drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$4,250 individual / \$8,500 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$15 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	\$25 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	\$25 co-payment per visit for chiropractic services, nutritional counseling, outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	20% co-insurance*	Not covered	Most services require prior approval.

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$5 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	\$50 deductible, then \$40 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	\$50 deductible, then 50% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	20% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	20% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$150 co-payment per visit for facility services; no charge* for physician services	\$150 co-payment per visit for facility services; no charge* for physician services	Must meet emergency criteria. Co-payment waived if admitted.
	Emergency medical transportation	\$50 co-payment per member per day	\$50 co-payment per member per day	Must meet emergency criteria.
	Urgent care	\$45 co-payment per visit	\$45 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance*	Not covered	None
	Physician / surgeon fee	20% co-insurance*	Not covered	Some services require prior approval.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	20% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	20% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	20% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	20% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	20% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	20% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	20% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	20% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	20% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	20% co-insurance*	Not covered	May require prior approval.
	Hospice	20% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	\$25 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	\$25 co-payment 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: 30% co-insurance*, Class III: 50% co-insurance* 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:**

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing aids</li> <li>• Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>• Infertility treatment</li> <li>• Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (age 21 and older)</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul>

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### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

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The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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- **CHINESE (中文):** 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- **NAVAJO (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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if they are covered under different plans.



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 (normal delivery)

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Hospital Charges (baby)	\$900
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Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$750
Co-pays	\$10
Coinsurance	\$880
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,790</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$3,920
- **Patient pays :** \$1,480

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$750
Co-pays	\$430
Coinsurance	\$220
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,480</b>

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

## Coverage Examples

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-STANDARD-GOLD-X-BASE(MD15337) BCBS-RxHIX-50-1250-x-5-40-0.5-x-P(RX15338) CY 1014726

\$35 PCP / \$80 Specialist co-payment, \$3,500 / \$7,000 Deductible  
 Pharmacy: \$20 co-payment / \$80 co-payment / 60% co-insurance, \$300 Rx Deductible  
**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$3,500 individual / \$7,000 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, prescription drugs or dental class I.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	Yes. \$300 prescription drug deductible per member.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$6,350 individual / \$12,700 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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\$35 PCP / \$80 Specialist co-payment, \$3,500 / \$7,000 Deductible  
 Pharmacy: \$20 co-payment / \$80 co-payment / 60% co-insurance, \$300 Rx Deductible  
**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**



**Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.

**Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)

This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge	\$35 co-payment* per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge	\$80 co-payment* per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	No charge	\$80 co-payment* per visit for chiropractic care, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.

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\$35 PCP / \$80 Specialist co-payment, \$3,500 / \$7,000 Deductible  
 Pharmacy: \$20 co-payment / \$80 co-payment / 60% co-insurance, \$300 Rx Deductible  
**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	50% co-insurance*	Not covered	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about <a href="http://www.bcbsvt.com/rxcenter">prescription drug coverage</a> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge	\$300 deductible, then \$20 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge	\$300 deductible, then \$80 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	No charge	\$300 deductible, then 60% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	No charge	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% co-insurance*	Not covered	Some services require prior approval.
	Physician/surgeon fees	No charge	50% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	No charge	50% co-insurance* for facility and physician services	50% co-insurance* for facility and physician services	Must meet emergency criteria.

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\$35 PCP / \$80 Specialist co-payment, \$3,500 / \$7,000 Deductible  
 Pharmacy: \$20 co-payment / \$80 co-payment / 60% co-insurance, \$300 Rx Deductible  
**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency medical transportation	No charge	\$100 co-payment* per member per day	\$100 co-payment* per member per day	Must meet emergency criteria.
	Urgent care	No charge	\$100 co-payment* per visit	\$100 co-payment* per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% co-insurance*	Not covered	None
	Physician/surgeon fee	No charge	50% co-insurance*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	50% co-insurance*	Not covered	Some services require prior approval.
	Mental/Behavioral health inpatient services	No charge	50% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge	50% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge	50% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	No charge	Not covered	None
	Delivery and all inpatient services	No charge	50% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	50% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge	50% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	No charge	50% co-insurance* per inpatient services	Not covered	Requires prior approval.

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 Pharmacy: \$20 co-payment / \$80 co-payment / 60% co-insurance, \$300 Rx Deductible  
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Skilled nursing care (facility)	No charge	50% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	No charge	50% co-insurance*	Not covered	May require prior approval.
	Hospice	No charge	50% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	No charge	\$80 co-payment* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	No charge	\$80 co-payment* 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	No charge	Child: Class I: No charge, Class II: 30% co-insurance*, Class III: 50% co-insurance* 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:**

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing aids</li> <li>• Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>• Infertility treatment</li> <li>• Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (age 21 and older)</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul>

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**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

**Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

**Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

**Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$3,030
- **Patient pays :** \$4,510

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$3,520
Co-pays	\$0
Coinsurance	\$840
Limits or exclusions	\$150
<b>Total</b>	<b>\$4,510</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$1,920
- **Patient pays :** \$3,480

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$2,620
Co-pays	\$780
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$3,480</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-STANDARD-BRONZE-NA-BASE(MD15361) BCBS-RxHIXNativeAmerican-200-1250-x-20-80-0.60-x-P(RX15392) CY 1014722

**Template Name :** MedHIX-NativeAmerican-3-Network-012015

\$15 PCP / \$25 Specialist co-payment, \$750 / \$1,500 Deductible

Pharmacy: \$5 co-payment / \$40 co-payment / 50% co-insurance; \$50 Rx Deductible (waived for Generics)

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$750 individual / \$1,500 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, emergency services, prescription drugs or dental class I.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	Yes. \$50 prescription drug deductible per member. Does not apply to generic drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$4,250 individual / \$8,500 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

#You will pay no cost share when you receive care from a provider that is an Indian Health Service or Indian Tribe, Tribal Organization, or Urban Indian Organization. **Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

**SNO/BPN:** 1014725 /

\$15 PCP / \$25 Specialist co-payment, \$750 / \$1,500 Deductible

Pharmacy: \$5 co-payment / \$40 co-payment / 50% co-insurance; \$50 Rx Deductible (waived for Generics)

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.

**Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)

This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge	\$15 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge	\$25 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	No charge	\$25 co-payment per visit for chiropractic care, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	20% co-insurance*	Not covered	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge	\$5 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge	\$50 deductible, then \$40 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	No charge	\$50 deductible, then 50% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	No charge	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% co-insurance*	Not covered	Some services require prior approval.
	Physician/surgeon fees	No charge	20% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	No charge	\$150 co-payment per visit for facility services; no charge for physician services	\$150 co-payment per visit for facility services; no charge for physician services	Must meet emergency criteria. Co-payment waived if admitted.

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**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency medical transportation	No charge	\$50 co-payment per member per day	\$50 co-payment per member per day	Must meet emergency criteria.
	Urgent care	No charge	\$45 co-payment per visit	\$45 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% co-insurance*	Not covered	None
	Physician/surgeon fee	No charge	20% co-insurance*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	20% co-insurance*	Not covered	Some services require prior approval.
	Mental/Behavioral health inpatient services	No charge	20% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge	20% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge	20% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	No charge	Not covered	None
	Delivery and all inpatient services	No charge	20% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	20% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge	20% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	No charge	20% co-insurance* for inpatient services	Not covered	Requires prior approval.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Skilled nursing care (facility)	No charge	20% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	No charge	20% co-insurance*	Not covered	May require prior approval.
	Hospice	No charge	20% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	No charge	\$25 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	No charge	\$25 co-payment 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	No charge	Child: Class I: No charge, Class II: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$5,750
- **Patient pays :** \$1,790

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$750
Co-pays	\$10
Coinsurance	\$880
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,790</b>

**Managing type 2 diabetes**  
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$3,920
- **Patient pays :** \$1,480

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$750
Co-pays	\$430
Coinsurance	\$220
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,480</b>

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## Coverage Examples

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-STANDARD-GOLD-NA-BASE(MD15360) BCBS-RxHIXNativeAmerican-50-1250-x-5-40-0.5-x-P(RX15391) CY 1014725

\$10 PCP / \$20 Specialist co-payment, \$150 / \$300 Deductible  
 Pharmacy: \$5 co-payment / \$40 co-payment / 50% co-insurance

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$150 individual / \$300 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, emergency services, prescription drugs or dental class I.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$1,250 individual / \$2,500 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
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This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

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If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge	\$10 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge	\$20 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	No charge	\$20 co-payment per visit for chiropractic care, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	10% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.

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\$10 PCP / \$20 Specialist co-payment, \$150 / \$300 Deductible  
 Pharmacy: \$5 co-payment / \$40 co-payment / 50% co-insurance

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	10% co-insurance*	Not covered	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge	\$5 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge	\$40 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	No charge	50% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	No charge	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	10% co-insurance*	Not covered	Some services require prior approval.
	Physician/surgeon fees	No charge	10% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	No charge	\$100 co-payment per visit for facility services; no charge for physician services	\$100 co-payment per visit for facility services; no charge for physician services	Must meet emergency criteria. Co-payment waived if admitted.

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\$10 PCP / \$20 Specialist co-payment, \$150 / \$300 Deductible  
 Pharmacy: \$5 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency medical transportation	No charge	\$50 co-payment per member per day	\$50 co-payment per member per day	Must meet emergency criteria.
	Urgent care	No charge	\$40 co-payment per visit	\$40 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% co-insurance*	Not covered	None
	Physician/surgeon fee	No charge	10% co-insurance*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	10% co-insurance*	Not covered	Some services require prior approval.
	Mental/Behavioral health inpatient services	No charge	10% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge	10% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge	10% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	No charge	Not covered	None
	Delivery and all inpatient services	No charge	10% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	10% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge	10% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	No charge	10% co-insurance* for inpatient services	Not covered	Requires prior approval.

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 Pharmacy: \$5 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Skilled nursing care (facility)	No charge	10% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	No charge	10% co-insurance*	Not covered	May require prior approval.
	Hospice	No charge	10% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	No charge	\$20 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	No charge	\$20 co-payment 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	No charge	Child: Class I: No charge, Class II: 30% co-insurance*, Class III: 50% co-insurance* 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:**

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

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**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

**Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

**Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

**Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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\$10 PCP / \$20 Specialist co-payment, \$150 / \$300 Deductible  
 Pharmacy: \$5 co-payment / \$40 co-payment / 50% co-insurance

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$6,730
- **Patient pays :** \$810

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$150
Co-pays	\$10
Coinsurance	\$500
Limits or exclusions	\$150
<b>Total</b>	<b>\$810</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$4,640
- **Patient pays :** \$760

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$150
Co-pays	\$400
Coinsurance	\$130
Limits or exclusions	\$80
<b>Total</b>	<b>\$760</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-STANDARD-PLATINUM-NA-BASE(MD15362) BCBS-RxHIXNativeAmerican-0-1250-x-5-40-0.5-x-P(RX15393) CY 1014727

\$25 PCP / \$45 Specialist co-payment, \$1,900 / \$3,800 Deductible

Pharmacy: \$12 co-payment / \$50 co-payment / 50% co-insurance; \$100 Rx Deductible (waived for Generics)

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$1,900 individual / \$3,800 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, prescription drugs or dental class I.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	Yes. \$100 prescription drug deductible per member. Does not apply to generic drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$5,100 individual / \$10,200 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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SNO/BPN: 1014729 /

\$25 PCP / \$45 Specialist co-payment, \$1,900 / \$3,800 Deductible

Pharmacy: \$12 co-payment / \$50 co-payment / 50% co-insurance; \$100 Rx Deductible (waived for Generics)

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.

**Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)

This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge	\$25 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge	\$45 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	No charge	\$45 co-payment per visit for chiropractic care, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	40% co-insurance*	Not covered	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge	\$12 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge	\$100 deductible, then \$50 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	No charge	\$100 deductible, then 50% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	No charge	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% co-insurance*	Not covered	Some services require prior approval.
	Physician/surgeon fees	No charge	40% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	No charge	\$250 co-payment* per visit for facility services; no charge* for physician services	\$250 co-payment* per visit for facility services; no charge* for physician services	Must meet emergency criteria.

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency medical transportation	No charge	\$100 co-payment per member per day	\$100 co-payment per member per day	Must meet emergency criteria.
	Urgent care	No charge	\$60 co-payment per visit	\$60 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% co-insurance*	Not covered	None
	Physician/surgeon fee	No charge	40% co-insurance*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	40% co-insurance*	Not covered	Some services require prior approval.
	Mental/Behavioral health inpatient services	No charge	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge	40% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	No charge	Not covered	None
	Delivery and all inpatient services	No charge	40% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	40% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge	40% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	No charge	40% co-insurance* for inpatient services	Not covered	Requires prior approval.

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SNO/BPN: 1014729 /

\$25 PCP / \$45 Specialist co-payment, \$1,900 / \$3,800 Deductible  
 Pharmacy: \$12 co-payment / \$50 co-payment / 50% co-insurance; \$100 Rx Deductible (waived for Generics)

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Skilled nursing care (facility)	No charge	40% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	No charge	40% co-insurance*	Not covered	May require prior approval.
	Hospice	No charge	40% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	No charge	\$45 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	No charge	\$45 co-payment 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	No charge	Child: Class I: No charge, Class II: 30% co-insurance*, Class III: 50% co-insurance* 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:**

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (800) 255-4550.

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**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$4,160
- **Patient pays :** \$3,380

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$1,900
Co-pays	\$20
Coinsurance	\$1,310
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,380</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$2,490
- **Patient pays :** \$2,910

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$1,900
Co-pays	\$560
Coinsurance	\$370
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,910</b>

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## Coverage Examples

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

\* **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

\* **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-STANDARD-SILVER-NA-BASE(MD15363) BCBS-RxHIXNativeAmerican-100-1250-x-12-50-0.5-x-P(RX16176) CY 1014729

**Template Name :** MedHIX-NativeAmerican-3-Network-012015

\$0 / \$0 Deductible

Pharmacy: No charge

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$0 individual / \$0 family.	See the chart starting on page 2 for your costs for services this plan covers. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$0 individual / \$0 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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**SNO/BPN:** 1014735 /

\$0 / \$0 Deductible

Pharmacy: No charge

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.

**Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)

This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge	No charge for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge	No charge	Not covered	Some services require prior approval.
	Other practitioner office visit	No charge	No charge for chiropractic care, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Not covered	Most services require prior approval.

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**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Provider	In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge	No charge	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge	No charge	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	No charge	No charge	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	No charge	Wellness prescription drugs will process at No charge for generic, preferred and non-preferred drugs.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Not covered	Some services require prior approval.
	Physician/surgeon fees	No charge	No charge	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	No charge	No charge for facility and physician services	No charge for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	No charge	No charge	No charge	Must meet emergency criteria.

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**Coverage Period Begins: 01/01/2015**
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Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Provider	In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Urgent care	No charge	No charge	No charge	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Not covered	None
	Physician/surgeon fee	No charge	No charge	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	No charge	Not covered	Some services require prior approval.
	Mental/Behavioral health inpatient services	No charge	No charge	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge	No charge	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge	No charge	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	No charge	Not covered	None
	Delivery and all inpatient services	No charge	No charge	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge	No charge inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	No charge	No charge for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	No charge	No charge	Not covered	Requires prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Provider	In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Durable medical equipment (including supplies)	No charge	No charge	Not covered	May require prior approval.
	Hospice	No charge	No charge	Not covered	None
If you or your child needs dental or eye care	Eye exam	No charge	No charge per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	No charge	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	No charge	Child: Class I: No charge, Class II: 30% co-insurance, Class III: 50% co-insurance 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.

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<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
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- Bariatric surgery (requires prior approval)
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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (800) 255-4550.

#You will pay no cost share when you receive care from a provider that is an Indian Health Service or Indian Tribe, Tribal Organization, or Urban Indian Organization. **Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy.

**SNO/BPN:** 1014735 /

\$0 / \$0 Deductible  
Pharmacy: No charge

Coverage Period Begins: 01/01/2015  
Coverage For: All Plan Type: EPO

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
(normal delivery)

- Amount owed to providers: \$7,540
- Plan Pays: \$7,390
- Patient pays : \$150

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$0
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$150</b>

**Managing type 2 diabetes**  
(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan Pays: \$5,320
- Patient pays : \$80

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$0
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$80</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-STANDARD-X-NA-BASE(MD15371) BCBS-RxHIXNativeAmerican-0-0-x-0-0-x-P(RX15399) CY 1014735

**Template Name :** MedHIX-NativeAmerican-3-Network-012015

\$10 PCP / \$20 Specialist co-payment, \$150 / \$300 Deductible  
 Pharmacy: \$5 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$150 individual / \$300 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, emergency services, prescription drugs or dental class I.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$1,250 individual / \$2,500 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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\$10 PCP / \$20 Specialist co-payment, \$150 / \$300 Deductible  
 Pharmacy: \$5 co-payment / \$40 co-payment / 50% co-insurance

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$10 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	\$20 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	\$20 co-payment per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	10% co-insurance*	Not covered	Most services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$5 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	\$40 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	50% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	10% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	10% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$100 co-payment per visit for facility services; no charge for physician services	\$100 co-payment per visit for facility services; no charge for physician services	Must meet emergency criteria. Co-payment waived if admitted.
	Emergency medical transportation	\$50 co-payment per member per day	\$50 co-payment per member per day	Must meet emergency criteria.
	Urgent care	\$40 co-payment per visit	\$40 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance*	Not covered	None
	Physician / surgeon fee	10% co-insurance*	Not covered	Some services require prior approval.

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\$10 PCP / \$20 Specialist co-payment, \$150 / \$300 Deductible  
 Pharmacy: \$5 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	10% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	10% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	10% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	10% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	10% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	10% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	10% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	10% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	10% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	10% co-insurance*	Not covered	May require prior approval.
	Hospice	10% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	\$20 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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\$10 PCP / \$20 Specialist co-payment, \$150 / \$300 Deductible  
 Pharmacy: \$5 co-payment / \$40 co-payment / 50% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	\$20 co-payment 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: 30% co-insurance*, Class III: 50% co-insurance* 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:**

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

<b>Other Covered Services</b> (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>Bariatric surgery (requires prior approval)</li> <li>Private-duty nursing (covered up to 14 hours per member per plan year)</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care (requires prior approval after 12 visits)</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S. (<a href="http://www.bcbsvt.com/coveragewhiletraveling">www.bcbsvt.com/coveragewhiletraveling</a>)</li> </ul>

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### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- **SPANISH (Español):** Para obtener asistencia en Español, llame al (800) 255-4550.
- **TAGALOG (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- **CHINESE (中文):** 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- **NAVAJO (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$6,730
- **Patient pays :** \$810

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$150
Co-pays	\$10
Coinsurance	\$500
Limits or exclusions	\$150
<b>Total</b>	<b>\$810</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$4,640
- **Patient pays :** \$760

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$150
Co-pays	\$400
Coinsurance	\$130
Limits or exclusions	\$80
<b>Total</b>	<b>\$760</b>

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

**Standard Plan Name:** BCBS-EPO-X-STANDARD-PLATINUM-X-BASE(MD15336) BCBS-RxHIX-0-1250-x-5-40-0.5-x-P(RX15337) CY 1014728

\$25 PCP / \$45 Specialist co-payment, \$1,900 / \$3,800 Deductible

Pharmacy: \$12 co-payment / \$50 co-payment / 50% co-insurance; \$100 Rx Deductible (waived for Generics)

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$1,900 individual / \$3,800 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, prescription drugs or dental class I.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	Yes. \$100 prescription drug deductible per member. Does not apply to generic drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$4,000 individual / \$8,000 family. Prescription drugs are limited to \$1,200 individual / \$2,400 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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\$25 PCP / \$45 Specialist co-payment, \$1,900 / \$3,800 Deductible

Pharmacy: \$12 co-payment / \$50 co-payment / 50% co-insurance; \$100 Rx Deductible (waived for Generics)

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$25 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	\$45 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	\$45 co-payment per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	40% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	40% co-insurance*	Not covered	Most services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$12 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	\$100 deductible, then \$50 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	\$100 deductible, then 50% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	40% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	40% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$250 co-payment* per visit for facility services; no charge* for physician services	\$250 co-payment* per visit for facility services; no charge* for physician services	Must meet emergency criteria.
	Emergency medical transportation	\$100 co-payment per member per day	\$100 co-payment per member per day	Must meet emergency criteria.
	Urgent care	\$60 co-payment per visit	\$60 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-insurance*	Not covered	None
	Physician / surgeon fee	40% co-insurance*	Not covered	Some services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	40% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	40% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	40% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	40% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	40% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	40% co-insurance*	Not covered	May require prior approval.
	Hospice	40% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	\$45 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	\$45 co-payment 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: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>Bariatric surgery (requires prior approval)</li> <li>Private-duty nursing (covered up to 14 hours per member per plan year)</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care (requires prior approval after 12 visits)</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S. (<a href="http://www.bcbsvt.com/coveragewhiletraveling">www.bcbsvt.com/coveragewhiletraveling</a>)</li> </ul>

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$4,160
- **Patient pays :** \$3,380

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$1,900
Co-pays	\$20
Coinsurance	\$1,310
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,380</b>

**Managing type 2 diabetes**  
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$2,490
- **Patient pays :** \$2,910

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$1,900
Co-pays	\$560
Coinsurance	\$370
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,910</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-STANDARD-SILVER-X-73AV(MD15347) BCBS-RxHIX-100-1200-x-12-50-0.5-x-P(RX15346) CY 1014730

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**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$1,500 individual / \$3,000 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, prescription drugs or dental class I.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	Yes. \$100 prescription drug deductible per member. Does not apply to generic drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$3,000 individual / \$6,000 family. Prescription drugs are limited to \$1,000 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
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- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$20 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	\$40 co-payment per visit	Not covered	Some services require prior approval.
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If you have a test	Diagnostic test (x-ray, blood work)	40% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$12 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	\$100 deductible, then \$50 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	\$100 deductible, then 50% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	40% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	40% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$250 co-payment* per visit for facility services; no charge* for physician services	\$250 co-payment* per visit for facility services; no charge* for physician services	Must meet emergency criteria.
	Emergency medical transportation	\$100 co-payment per member per day	\$100 co-payment per member per day	Must meet emergency criteria.
	Urgent care	\$60 co-payment per visit	\$60 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-insurance*	Not covered	None
	Physician / surgeon fee	40% co-insurance*	Not covered	Some services require prior approval.

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\$20 PCP / \$40 Specialist co-payment, \$1,500 / \$3,000 Deductible

Pharmacy: \$12 co-payment / \$50 co-payment / 50% co-insurance; \$100 Rx Deductible (waived for Generics)

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	40% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	40% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	40% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	40% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	40% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	40% co-insurance*	Not covered	May require prior approval.
	Hospice	40% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	\$40 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	\$40 co-payment 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: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>Bariatric surgery (requires prior approval)</li> <li>Private-duty nursing (covered up to 14 hours per member per plan year)</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care (requires prior approval after 12 visits)</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S. (<a href="http://www.bcbsvt.com/coveragewhiletraveling">www.bcbsvt.com/coveragewhiletraveling</a>)</li> </ul>

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- **SPANISH (Español):** Para obtener asistencia en Español, llame al (800) 255-4550.
- **TAGALOG (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- **CHINESE (中文):** 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- **NAVAJO (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$4,400
- **Patient pays :** \$3,140

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$1,500
Co-pays	\$20
Coinsurance	\$1,470
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,140</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$2,800
- **Patient pays :** \$2,600

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$1,500
Co-pays	\$600
Coinsurance	\$420
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,600</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-STANDARD-SILVER-X-77AV(MD15373) BCBS-RxHIX-100-1000-x-12-50-0.5-x-P(RX16177) CY 1014731

\$10 PCP / \$30 Specialist co-payment, \$600 / \$1,200 Deductible

Pharmacy: \$10 co-payment / \$50 co-payment / 50% co-insurance; \$100 Rx Deductible (waived for Generics)

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$600 individual / \$1,200 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, prescription drugs or dental class I.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	Yes. \$100 prescription drug deductible per member. Does not apply to generic drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$1,250 individual / \$2,500 family. Prescription drugs are limited to \$400 individual / \$800 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$10 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	\$30 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	\$30 co-payment per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	40% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	40% co-insurance*	Not covered	Most services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$10 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	\$100 deductible, then \$50 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	\$100 deductible, then 50% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	40% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	40% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$250 co-payment* per visit for facility services; no charge* for physician services	\$250 co-payment* per visit for facility services; no charge* for physician services	Must meet emergency criteria.
	Emergency medical transportation	\$100 co-payment per member per day	\$100 co-payment per member per day	Must meet emergency criteria.
	Urgent care	\$50 co-payment per visit	\$50 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-insurance*	Not covered	None
	Physician / surgeon fee	40% co-insurance*	Not covered	Some services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	40% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	40% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	40% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	40% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	40% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	40% co-insurance*	Not covered	May require prior approval.
	Hospice	40% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	\$30 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	\$30 co-payment 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: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)		
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\$10 PCP / \$30 Specialist co-payment, \$600 / \$1,200 Deductible

Pharmacy: \$10 co-payment / \$50 co-payment / 50% co-insurance; \$100 Rx Deductible (waived for Generics)

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

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If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

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The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

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**Coverage Period Begins: 01/01/2014**

**Coverage For: All Plan Type: EPO**

**Coverage Examples**

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These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

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See the next page for important information about these examples.

**Having a baby**  
(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$6,140
- **Patient pays :** \$1,400

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$750
Co-pays	\$0
Coinsurance	\$500
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,400</b>

**Managing type 2 diabetes**  
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$4,070
- **Patient pays :** \$1,330

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$750
Co-pays	\$320
Coinsurance	\$180
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,330</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-STANDARD-SILVER-X-87AV(MD15348) BCBS-RxHIX-100-400-x-10-50-0.5-x-P(RX15352) CY 1014732

\$5 PCP / \$15 Specialist co-payment, \$100 / \$200 Deductible  
 Pharmacy: \$5 co-payment / \$20 co-payment / 30% co-insurance

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$100 individual / \$200 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, prescription drugs or dental class I.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$500 individual / \$1,000 family. Prescription drugs are limited to \$200 individual / \$400 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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 Pharmacy: \$5 co-payment / \$20 co-payment / 30% co-insurance

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$5 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	\$15 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	\$15 co-payment per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	10% co-insurance*	Not covered	Most services require prior approval.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$5 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	\$20 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	30% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	10% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	10% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$75 co-payment* per visit for facility services; no charge* for physician services	\$75 co-payment* per visit for facility services; no charge* for physician services	Must meet emergency criteria.
	Emergency medical transportation	\$50 co-payment per member per day	\$50 co-payment per member per day	Must meet emergency criteria.
	Urgent care	\$35 co-payment per visit	\$35 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance*	Not covered	None
	Physician / surgeon fee	10% co-insurance*	Not covered	Some services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	10% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	10% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	10% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	10% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	10% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	10% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	10% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	10% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	10% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	10% co-insurance*	Not covered	May require prior approval.
	Hospice	10% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	\$15 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	\$15 co-payment 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: 30% co-insurance*, Class III: 50% co-insurance* 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:**

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing aids</li> <li>• Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>• Infertility treatment</li> <li>• Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (age 21 and older)</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul>

<b>Other Covered Services</b> (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)		
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The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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- **NAVAJO (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

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**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$6,890
- **Patient pays :** \$650

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$100
Co-pays	\$0
Coinsurance	\$400
Limits or exclusions	\$150
<b>Total</b>	<b>\$650</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$4,820
- **Patient pays :** \$580

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$100
Co-pays	\$290
Coinsurance	\$110
Limits or exclusions	\$80
<b>Total</b>	<b>\$580</b>

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-STANDARD-SILVER-X-94AV(MD15349) BCBS-RxHIX-0-200-x-5-20-0.3-x-P(RX15348) CY 1014733

\$25 PCP / \$45 Specialist co-payment, \$1,900 / \$3,800 Deductible

Pharmacy: \$12 co-payment / \$50 co-payment / 50% co-insurance; \$100 Rx Deductible (waived for Generics)

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$1,900 individual / \$3,800 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, prescription drugs or dental class I.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	Yes. \$100 prescription drug deductible per member. Does not apply to generic drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$5,100 individual / \$10,200 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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\$25 PCP / \$45 Specialist co-payment, \$1,900 / \$3,800 Deductible

Pharmacy: \$12 co-payment / \$50 co-payment / 50% co-insurance; \$100 Rx Deductible (waived for Generics)

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$25 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	\$45 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	\$45 co-payment per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	40% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	40% co-insurance*	Not covered	Most services require prior approval.

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$12 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	\$100 deductible, then \$50 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	\$100 deductible, then 50% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	40% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	40% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$250 co-payment* per visit for facility services; no charge* for physician services	\$250 co-payment* per visit for facility services; no charge* for physician services	Must meet emergency criteria.
	Emergency medical transportation	\$100 co-payment per member per day	\$100 co-payment per member per day	Must meet emergency criteria.
	Urgent care	\$60 co-payment per visit	\$60 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-insurance*	Not covered	None
	Physician / surgeon fee	40% co-insurance*	Not covered	Some services require prior approval.

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**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	40% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	40% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	40% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	40% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	40% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	40% co-insurance*	Not covered	May require prior approval.
	Hospice	40% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	\$45 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	\$45 co-payment 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: 30% co-insurance*, Class III: 50% co-insurance* 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:**

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing aids</li> <li>• Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>• Infertility treatment</li> <li>• Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (age 21 and older)</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul>

<b>Other Covered Services</b> (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>• Bariatric surgery (requires prior approval)</li> <li>• Private-duty nursing (covered up to 14 hours per member per plan year)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care (requires prior approval after 12 visits)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S. (<a href="http://www.bcbsvt.com/coveragewhiletraveling">www.bcbsvt.com/coveragewhiletraveling</a>)</li> </ul>

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Pharmacy: \$12 co-payment / \$50 co-payment / 50% co-insurance; \$100 Rx Deductible (waived for Generics)

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- **SPANISH (Español):** Para obtener asistencia en Español, llame al (800) 255-4550.
- **TAGALOG (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- **CHINESE (中文):** 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- **NAVAJO (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/standard-cert](http://www.bcbsvt.com/standard-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$20 PCP / \$40 Specialist co-payment, \$1,900 / \$3,800 Deductible  
 Pharmacy: \$12 co-payment / \$50 co-payment / 50% co-insurance; \$100 Rx Deductible (waived for Generics)

**Coverage Period Begins: 01/01/2014**  
**Coverage For: All Plan Type: EPO**

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$4,160
- **Patient pays :** \$3,380

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$1,900
Co-pays	\$20
Coinsurance	\$1,310
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,380</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$2,490
- **Patient pays :** \$2,910

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$1,900
Co-pays	\$560
Coinsurance	\$370
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,910</b>

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**Coverage Examples**

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-STANDARD-SILVER-X-BASE(MD15338) BCBS-RxHIX-100-1250-x-12-50-0.5-x-P(RX15339) CY 1014734



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$1,250 individual / \$2,500 family. Co-insurance and co-payments do not count towards the deductible. Deductible and co-payments do not apply to dental class I, preventive care or 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. This benefit combines your prescription drug and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$4,250 individual / \$8,500 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

Important Questions	Answers	Why this matters:
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$20 co-payment* per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	\$30 co-payment* per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	\$30 co-payment* per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a test	Diagnostic test (x-ray, blood work)	\$30 co-payment* per visit for office-based and outpatient hospital	Not covered	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.
	Imaging (CT/PET scans, MRIs)	\$500 co-payment* per visit	Not covered	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$5 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	40% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	60% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 co-payment* per visit	Not covered	Some services require prior approval.
	Physician/surgeon fees	No charge*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$250 co-payment* per visit for facility services; no charge for physician services	\$250 co-payment* per visit for facility services; no charge for physician services	Must meet emergency criteria.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency medical transportation	\$30 co-payment* per member per day	\$30 co-payment* per member per day	Must meet emergency criteria.
	Urgent care	\$30 co-payment* per visit	\$30 co-payment* per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 co-payment* per admission	Not covered	None
	Physician/surgeon fee	No charge*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	\$500 co-payment* per visit	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	\$500 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	\$500 co-payment* per visit	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	\$500 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	\$500 co-payment* per admission	Not covered	None
If you need help recovering or have other special health needs	Home health care	\$30-copayment*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	\$500 co-payment* per inpatient admission; no charge for cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	\$500 co-payment* per inpatient admission	Not covered	Requires prior approval.
	Skilled nursing care (facility)	\$500 co-payment* per admission	Not covered	Requires prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Durable medical equipment (including supplies)	\$30-co-payment*	Not covered	May require prior approval.
	Hospice	No charge*	Not covered	None
If your child needs dental or eye care	Eye exam	\$30 co-payment* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	\$30 co-payment* 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: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

**Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

**Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

**Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (800) 255-4550.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$5,630
- **Patient pays :** \$1,910

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$1,250
Co-pays	\$510
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,910</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$3,310
- **Patient pays :** \$2,090

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$1,250
Co-pays	\$760
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,090</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-NONSTANDARD-GOLD-X-BASE(MD15342) BCBS-RxHIXNS-0-1250-x-5-0.40-0.60-x-P(RX16178) CY 1014925

\$20 PCP / \$30 Specialist co-payment, \$1,250 / \$2,500 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$1,250 individual / \$2,500 family. Co-insurance and co-payments do not count towards the deductible. Deductible and co-payments do not apply to dental class I, preventive care or 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. This benefit combines your prescription drug and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$4,250 individual / \$8,500 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.

#You will pay no cost share when you receive care from a provider that is an Indian Health Service or Indian Tribe, Tribal Organization, or Urban Indian Organization. **Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

SNO/BPN: 1014714 /

\$20 PCP / \$30 Specialist co-payment, \$1,250 / \$2,500 Deductible  
 Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Coverage Period Begins: 01/01/2015**  
**Coverage For: All Plan Type: EPO**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Important Questions	Answers	Why this matters:
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.



**Co-payments** are fixed dollar amounts (for example \$15) you pay for covered health care usually when you receive the service.

**Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)

This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge	\$20 co-payment* per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge	\$30 co-payment* per visit	Not covered	
	Other practitioner office visit	No charge	\$30 co-payment* per visit for chiropractic care, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	

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\$20 PCP / \$30 Specialist co-payment, \$1,250 / \$2,500 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Preventive care / Screening / Immunization	No charge	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	\$30 co-payment* per visit for office-based and outpatient hospital	Not covered	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.
	Imaging (CT/PET scans, MRIs)	No charge	\$500 co-payment* per visit	Not covered	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge	\$5 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge	40% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	No charge	60% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	No charge	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.

#You will pay no cost share when you receive care from a provider that is an Indian Health Service or Indian Tribe, Tribal Organization, or Urban Indian Organization. **Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

**SNO/BPN:** 1014714 /

\$20 PCP / \$30 Specialist co-payment, \$1,250 / \$2,500 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	\$500 co-payment* per visit	Not covered	Some services require prior approval.
	Physician/surgeon fees	No charge	No charge*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	No charge	\$250 co-payment* per visit for facility services; no charge* for physician services	\$250 co-payment* per visit for facility services; no charge* for physician services	Must meet emergency criteria.
	Emergency medical transportation	No charge	\$30 co-payment* per member per day	\$30 co-payment* per member per day	Must meet emergency criteria.
	Urgent care	No charge	\$30 co-payment* per visit	\$30 co-payment* per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$500 co-payment* per admission	Not covered	None
	Physician/surgeon fee	No charge	No charge*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	\$500 co-payment* per visit	Not covered	Some services require prior approval.
	Mental/Behavioral health inpatient services	No charge	\$500 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge	\$500 co-payment* per visit	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge	\$500 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	No charge	Not covered	None

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**SNO/BPN:** 1014714 /

\$20 PCP / \$30 Specialist co-payment, \$1,250 / \$2,500 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you are pregnant	Delivery and all inpatient services	No charge	\$500 co-payment* per admission	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	\$30-copayment*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge	\$500 co-payment* per inpatient admission; no charge* for cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	No charge	\$500 co-payment* per inpatient admission	Not covered	Requires prior approval.
	Skilled nursing care (facility)	No charge	\$500 co-payment* per admission	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	No charge	\$30-co-payment*	Not covered	May require prior approval.
	Hospice	No charge	No charge*	Not covered	None
If you or your child needs dental or eye care	Eye exam	No charge	\$30 co-payment* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	No charge	\$30 co-payment* 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	No charge	Child: Class I: No charge, Class II: 30% co-insurance*, Class III: 50% co-insurance* 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.

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Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check the policy or plan document for other [excluded services.](#))

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

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Coverage Examples**

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$5,630
- **Patient pays :** \$1,910

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$1,250
Co-pays	\$510
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,910</b>

**Managing type 2 diabetes**  
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$3,310
- **Patient pays :** \$2,090

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$1,250
Co-pays	\$760
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,090</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-NONSTANDARD-GOLD-NA-BASE(MD15366) BCBS-RxHIXNSNativeAmerican-0-1250-x-5-0.40-0.60-x-P(RX16179) CY 1014714

\$30 PCP / \$50 Specialist co-payment, \$2,000 / \$4,000 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$2,000 individual / \$4,000 family. Co-insurance and co-payments do not count towards the deductible. Deductible and co-payments do not apply to dental class I, preventive care or 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. This benefit combines your prescription drug and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$6,250 individual / \$12,500 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.

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SNO/BPN: 1014716 /

\$30 PCP / \$50 Specialist co-payment, \$2,000 / \$4,000 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Important Questions	Answers	Why this matters:
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.



**Co-payments** are fixed dollar amounts (for example \$15) you pay for covered health care usually when you receive the service.

**Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)

This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge	\$30 co-payment* per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge	\$50 co-payment* per visit	Not covered	
	Other practitioner office visit	No charge	\$50 co-payment* per visit for chiropractic care, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Preventive care / Screening / Immunization	No charge	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	\$50 co-payment* per visit for office-based and outpatient hospital	Not covered	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.
	Imaging (CT/PET scans, MRIs)	No charge	\$1,750 co-payment* per visit	Not covered	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge	\$5 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge	40% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	No charge	60% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	No charge	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.

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**SNO/BPN:** 1014716 /

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Physician/surgeon fees	No charge	No charge*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	No charge	\$250 co-payment* per visit for facility services; no charge* for physician services	\$250 co-payment* per visit for facility services; no charge* for physician services	Must meet emergency criteria.
	Emergency medical transportation	No charge	\$50 co-payment* per member per day	\$50 co-payment* per member per day	Must meet emergency criteria.
	Urgent care	No charge	\$50 co-payment* per visit	\$50 co-payment* per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$1,750 co-payment* per admission	Not covered	None
	Physician/surgeon fee	No charge	No charge*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Mental/Behavioral health inpatient services	No charge	\$1,750 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge	\$1,750 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	No charge	Not covered	None

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you are pregnant	Delivery and all inpatient services	No charge	\$1,750 co-payment* per admission	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	\$50 co-payment*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge	\$1,750 co-payment* per inpatient admission; no charge* for cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	No charge	\$1,750 co-payment* per inpatient admission	Not covered	Requires prior approval.
	Skilled nursing care (facility)	No charge	\$1,750 co-payment* per admission	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	No charge	\$50 co-payment*	Not covered	May require prior approval.
	Hospice	No charge	No charge*	Not covered	None
If you or your child needs dental or eye care	Eye exam	No charge	\$50 co-payment* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	No charge	\$50 co-payment* 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.

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**SNO/BPN:** 1014716 /

\$30 PCP / \$50 Specialist co-payment, \$2,000 / \$4,000 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Native American# Provider	In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Dental check-up	No charge	Child: Class I: No charge, Class II: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover** (This isn't a complete list. Check the policy or plan document for other [excluded services](#).)

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

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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**Coverage Examples**

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$3,630
- **Patient pays :** \$3,910

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$2,000
Co-pays	\$1,760
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,910</b>

**Managing type 2 diabetes**  
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$2,450
- **Patient pays :** \$2,950

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$2,000
Co-pays	\$870
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,950</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-NONSTANDARD-SILVER-NA-BASE(MD15367) BCBS-RxHIXNSNativeAmerican-0-1250-x-5-0.40-0.60-x-P(RX16179) CY 1014716

\$0 / \$0 Deductible

Pharmacy: No charge

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$0 individual / \$0 family.	See the chart starting on page 2 for your costs for services this plan covers. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$0 individual / \$0 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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**SNO/BPN:** 1015442 /

\$0 / \$0 Deductible

Pharmacy: No charge

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.

**Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)

This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	No charge	No charge for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	No charge	No charge	Not covered	Some services require prior approval.
	Other practitioner office visit	No charge	No charge for chiropractic care, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Not covered	Most services require prior approval.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Provider	In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	No charge	No charge	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	No charge	No charge	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	No charge	No charge	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	No charge	Wellness prescription drugs will process at No charge for generic, preferred and non-preferred drugs.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Not covered	Some services require prior approval.
	Physician/surgeon fees	No charge	No charge	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	No charge	No charge for facility and physician services	No charge for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	No charge	No charge	No charge	Must meet emergency criteria.

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**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Provider	In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Urgent care	No charge	No charge	No charge	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Not covered	None
	Physician/surgeon fee	No charge	No charge	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	No charge	Not covered	Some services require prior approval.
	Mental/Behavioral health inpatient services	No charge	No charge	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge	No charge	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge	No charge	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	No charge	Not covered	None
	Delivery and all inpatient services	No charge	No charge	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge	No charge inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	No charge	No charge for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	No charge	No charge	Not covered	Requires prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Provider	In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Durable medical equipment (including supplies)	No charge	No charge	Not covered	May require prior approval.
	Hospice	No charge	No charge	Not covered	None
If your child needs dental or eye care	Eye exam	No charge	No charge per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	No charge	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	No charge	Child: Class I: No charge, Class II: 30% co-insurance, Class III: 50% co-insurance 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 Does NOT Cover (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

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**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (requires prior approval)
- Private-duty nursing (covered up to 14 hours per member per plan year)
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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$7,390
- **Patient pays :** \$150

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$0
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$150</b>

**Managing type 2 diabetes**  
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$5,320
- **Patient pays :** \$80

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$0
Co-pays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$80</b>

#You will pay no cost share when you receive care from a provider that is an Indian Health Service or Indian Tribe, Tribal Organization, or Urban Indian Organization. **Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy.

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy.

**Standard Plan Name:** BCBS-EPO-X-NONSTANDARD-X-NA-BASE(MD16207) BCBS-RxHIXNativeAmerican-0-0-x-0-0-x-P(RX15399) CY 1015442

**Template Name :** MedHIX-NativeAmerican-3-Network-012015



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$1,550 individual / \$3,100 family. Co-insurance and co-payments do not count towards the deductible. Deductible and co-payments do not apply to dental class I, preventive care, 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. This benefit combines your prescription drug and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$5,200 individual / \$10,400 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$30 PCP / \$50 Specialist co-payment, \$1,550 / \$3,100 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Important Questions	Answers	Why this matters:
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$30 co-payment* per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	\$50 co-payment* per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	\$50 co-payment* per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$30 PCP / \$50 Specialist co-payment, \$1,550 / \$3,100 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a test	Diagnostic test (x-ray, blood work)	\$50 co-payment* per visit for office-based and outpatient hospital	Not covered	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.
	Imaging (CT/PET scans, MRIs)	\$1,750 co-payment* per visit	Not covered	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$5 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	40% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	60% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Physician / surgeon fees	No charge*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$250 co-payment* per visit for facility services; no charge* for physician services	\$250 co-payment* per visit for facility services; no charge* for physician services	Must meet emergency criteria.

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\$30 PCP / \$50 Specialist co-payment, \$1,550 / \$3,100 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency medical transportation	\$50 co-payment* per member per day	\$50 co-payment* per member per day	Must meet emergency criteria.
	Urgent care	\$50 co-payment* per visit	\$50 co-payment* per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,750 co-payment* per admission	Not covered	None
	Physician / surgeon fee	No charge*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	\$1,750 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	\$1,750 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	\$1,750 co-payment* per admission	Not covered	None
If you need help recovering or have other special health needs	Home health care	\$50 co-payment*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	\$1,750 co-payment* per inpatient admission; no charge* for cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	\$1,750 co-payment* per inpatient admission	Not covered	Requires prior approval.
	Skilled nursing care (facility)	\$1,750 co-payment* per admission	Not covered	Requires prior approval.

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\$30 PCP / \$50 Specialist co-payment, \$1,550 / \$3,100 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Durable medical equipment (including supplies)	\$50 co-payment*	Not covered	May require prior approval.
	Hospice	No charge*	Not covered	None
If you or your child needs dental or eye care	Eye exam	\$50 co-payment* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	\$50 co-payment* 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: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (800) 255-4550.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$4,080
- **Patient pays :** \$3,460

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$1,550
Co-pays	\$1,760
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,460</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$2,810
- **Patient pays :** \$2,590

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$1,550
Co-pays	\$960
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,590</b>

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

**Standard Plan Name:** BCBS-EPO-X-NONSTANDARD-SILVER-X-73AV(MD15353) BCBS-RxHIXNS-0-1250-x-5-0.40-0.60-x-P(RX16178) CY 1014717



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$1,000 individual / \$2,000 family. Co-insurance and co-payments do not count towards the deductible. Deductible and co-payments do not apply to preventive care or 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. This benefit combines your prescription drug and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$5,200 individual / \$10,400 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$30 PCP / \$50 Specialist co-payment, \$1,000 / \$2,000 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Important Questions	Answers	Why this matters:
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$30 co-payment* per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	\$50 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	\$50 co-payment per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a test	Diagnostic test (x-ray, blood work)	\$50 co-payment* per visit for office-based and outpatient hospital	Not covered	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.
	Imaging (CT/PET scans, MRIs)	\$1,750 co-payment* per visit	Not covered	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$5 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	40% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	60% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Physician / surgeon fees	No charge*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$250 co-payment* per visit for facility services; no charge for physician services	\$250 co-payment* per visit for facility services; no charge for physician services	Must meet emergency criteria.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency medical transportation	\$50 co-payment* per member per day	\$50 co-payment* per member per day	Must meet emergency criteria.
	Urgent care	\$50 co-payment* per visit	\$50 co-payment* per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,750 co-payment* per admission	Not covered	None
	Physician / surgeon fee	No charge*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	\$1,750 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	\$1,750 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	\$1,750 co-payment* per admission	Not covered	None
If you need help recovering or have other special health needs	Home health care	\$50 co-payment*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	\$1,750 co-payment* per inpatient admission; no charge for cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	\$1,750 co-payment* per inpatient admission	Not covered	Requires prior approval.
	Skilled nursing care (facility)	\$1,750 co-payment* per admission	Not covered	Requires prior approval.

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Durable medical equipment (including supplies)	\$50 co-payment*	Not covered	May require prior approval.
	Hospice	No charge*	Not covered	None
If you or your child needs dental or eye care	Eye exam	\$50 co-payment* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	\$50 co-payment* 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: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (800) 255-4550.

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$4,630
- **Patient pays :** \$2,910

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$1,000
Co-pays	\$1,760
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,910</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$3,220
- **Patient pays :** \$2,180

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$1,000
Co-pays	\$1,100
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,180</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-NONSTANDARD-SILVER-X-77AV(MD15774) BCBS-RxHIXNS-0-1250-x-5-0.40-0.60-x-P(RX16178) CY 1014718



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$200 individual / \$400 family. Co-insurance and co-payments do not count towards the deductible. Deductible and co-payments do not apply to dental class I, preventive care or 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. This benefit combines your prescription drug and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$2,250 individual / \$4,500 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

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**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Important Questions	Answers	Why this matters:
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$30 co-payment* per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	\$50 co-payment* per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	\$50 co-payment* per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a test	Diagnostic test (x-ray, blood work)	\$50 co-payment* per visit for office-based and outpatient hospital	Not covered	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.
	Imaging (CT/PET scans, MRIs)	\$1,750 co-payment* per visit	Not covered	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$5 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	40% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	60% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Physician / surgeon fees	No charge*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$250 co-payment* per visit for facility services; no charge* for physician services	\$250 co-payment* per visit for facility services; no charge* for physician services	Must meet emergency criteria.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

\$30 PCP / \$50 Specialist co-payment, \$200 / \$400 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency medical transportation	\$50 co-payment* per member per day	\$50 co-payment* per member per day	Must meet emergency criteria.
	Urgent care	\$50 co-payment* per visit	\$50 co-payment* per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,750 co-payment* per admission	Not covered	None
	Physician / surgeon fee	No charge*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	\$1,750 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	\$1,750 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	\$1,750 co-payment* per admission	Not covered	None
If you need help recovering or have other special health needs	Home health care	\$50 co-payment*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	\$1,750 co-payment* per inpatient admission; no charge* for cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	\$1,750 co-payment* per inpatient admission	Not covered	Requires prior approval.
	Skilled nursing care (facility)	\$1,750 co-payment* per admission	Not covered	Requires prior approval.

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Durable medical equipment (including supplies)	\$50 co-payment*	Not covered	May require prior approval.
	Hospice	No charge*	Not covered	None
If you or your child needs dental or eye care	Eye exam	\$50 co-payment* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	\$50 co-payment* 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: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

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Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

**Other Covered Services** (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

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

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (800) 255-4550.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$5,140
- **Patient pays :** \$2,400

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$200
Co-pays	\$2,050
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,400</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$3,730
- **Patient pays :** \$1,670

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$200
Co-pays	\$1,390
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,670</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-NONSTANDARD-SILVER-X-87AV(MD15354) BCBS-RxHIXNS-0-1250-x-5-0.40-0.60-x-P(RX16178) CY 1014719

\$15 PCP / \$35 Specialist co-payment, \$0 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$0 individual / \$0 family.	See the chart starting on page 2 for your costs for services this plan covers. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$850 individual / \$1,700 family. Prescription drugs are limited to \$850 individual / \$1,700 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$15 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	Some services require prior approval. Deductible and co-payments do not apply to some services see <a href="http://www.bcbsvt.com/nonstd-co-pays">www.bcbsvt.com/nonstd-co-pays</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> .
	Specialist visit	\$35 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	\$35 co-payment per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
If you have a test	Diagnostic test (x-ray, blood work)	\$35 co-payment per visit for office-based and outpatient hospital	Not covered	Some services require prior approval. Deductible and co-payments do not apply to some services see <a href="http://www.bcbsvt.com/nonstd-co-pays">www.bcbsvt.com/nonstd-co-pays</a> for more information.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Most services require prior approval.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**
**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$5 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	40% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	60% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	No charge	Not covered	Some services require prior approval.
	Physician / surgeon fees	No charge	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$250 co-payment per visit for facility services; no charge for physician services	\$250 co-payment per visit for facility services; no charge for physician services	Must meet emergency criteria. Co-payment waived if admitted.
	Emergency medical transportation	\$35 co-payment per member per day	\$35 co-payment per member per day	Must meet emergency criteria.
	Urgent care	\$35 co-payment per visit	\$35 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician / surgeon fee	No charge	Not covered	Some services require prior approval.

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**
**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	No charge	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	No charge	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	No charge	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	No charge	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	No charge	Not covered	None
If you need help recovering or have other special health needs	Home health care	\$35 co-payment	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	No charge inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	No charge for inpatient admission	Not covered	Requires prior approval.
	Skilled nursing care (facility)	No charge	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	\$35 co-payment	Not covered	May require prior approval.
	Hospice	No charge	Not covered	None
If you or your child needs dental or eye care	Eye exam	\$35 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	\$35 co-payment 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: 30% co-insurance, Class III: 50% co-insurance 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 Does NOT Cover (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing aids</li> <li>• Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>• Infertility treatment</li> <li>• Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (age 21 and older)</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>• Bariatric surgery (requires prior approval)</li> <li>• Private-duty nursing (covered up to 14 hours per member per plan year)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care (requires prior approval after 12 visits)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S. (<a href="http://www.bcbsvt.com/coveragewhiletraveling">www.bcbsvt.com/coveragewhiletraveling</a>)</li> </ul>

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\$15 PCP / \$35 Specialist co-payment, \$0 Deductible

Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period Begins: 01/01/2015**

**Coverage For: All Plan Type: EPO**

### Your Rights to Continue Coverage:

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- **NAVAJO (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 255-4550.

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\$15 PCP / \$35 Specialist co-payment, \$0 Deductible  
 Pharmacy: \$5 co-payment / 40% co-insurance / 60% co-insurance

**Coverage Period Begins: 01/01/2014**  
**Coverage For: All Plan Type: EPO**

**Coverage Examples**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



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Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$6,990
- **Patient pays :** \$550

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$0
Co-pays	\$400
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$550</b>

**Managing type 2 diabetes**  
 (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$4,320
- **Patient pays :** \$1,080

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$0
Co-pays	\$1,000
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,080</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Standard Plan Name:** BCBS-EPO-X-NONSTANDARD-SILVER-X-94AV(MD15355) BCBS-RxHIX-0-1000-x-5-0.40-0.60-x-P(RX15349) CY 1014720



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert) or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall <b>deductible</b> ?	\$2,000 individual / \$4,000 family. Co-insurance and co-payments do not count towards the deductible. Deductible and co-payments do not apply to dental class I, preventive care or 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. This benefit combines your prescription drug and medical deductibles.  *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For a family contract, the family deductible must be met before the plan pays benefits. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2015 through 12/31/2015.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. \$6,250 individual / \$12,500 family. Prescription drugs are limited to \$1,250 individual / \$2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of network providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the specialist you choose without permission from this plan.

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Important Questions	Answers	Why this matters:
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$30 co-payment* per visit for primary care physician and mental health / substance abuse	Not covered	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> .
	Specialist visit	\$50 co-payment* per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	\$50 co-payment* per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a test	Diagnostic test (x-ray, blood work)	\$50 co-payment* per visit for office-based and outpatient hospital	Not covered	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.
	Imaging (CT/PET scans, MRIs)	\$1,750 co-payment* per visit	Not covered	Most services require prior approval.
If you need drugs to treat your illness or condition. More information about <b>prescription drug coverage</b> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> .	Generic drugs	\$5 co-payment* per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	40% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	60% co-insurance*	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Physician / surgeon fees	No charge*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	\$250 co-payment* per visit for facility services; no charge* for physician services	\$250 co-payment* per visit for facility services; no charge for physician services	Must meet emergency criteria.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency medical transportation	\$50 co-payment* per member per day	\$50 co-payment* per member per day	Must meet emergency criteria.
	Urgent care	\$50 co-payment* per visit	\$50 co-payment* per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,750 co-payment* per admission	Not covered	None
	Physician / surgeon fee	No charge*	Not covered	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	\$1,750 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	\$1,750 co-payment* per visit	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	\$1,750 co-payment* per admission	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	\$1,750 co-payment* per admission	Not covered	None
If you need help recovering or have other special health needs	Home health care	\$50 co-payment*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	\$1,750 co-payment* per inpatient admission; no charge* for cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	\$1,750 co-payment* per inpatient admission	Not covered	Requires prior approval.
	Skilled nursing care (facility)	\$1,750 co-payment* per admission	Not covered	Requires prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Durable medical equipment (including supplies)	\$50 co-payment*	Not covered	May require prior approval.
	Hospice	No charge*	Not covered	None
If you or your child needs dental or eye care	Eye exam	\$50 co-payment* per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.
	Glasses	\$50 co-payment* 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: 30% co-insurance*, Class III: 50% co-insurance* 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 Does NOT Cover (This isn't a complete list. Check the policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility treatment</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

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- Private-duty nursing (covered up to 14 hours per member per plan year)
- Chiropractic Care (requires prior approval after 12 visits)
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- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (800) 255-4550.

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial

if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan Pays:** \$3,630
- **Patient pays :** \$3,910

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$2,000
Co-pays	\$1,760
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,910</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan Pays:** \$2,450
- **Patient pays :** \$2,950

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$2,000
Co-pays	\$870
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,950</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

\* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

\* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call (800) 255-4550 or visit us at [www.bcbsvt.com/nonstd-copay-cert](http://www.bcbsvt.com/nonstd-copay-cert). If you aren't clear about any of the bolded terms used in this form, see the [Glossary](#). You can view the [Glossary](#) at [www.bcbsvt.com/glossary](http://www.bcbsvt.com/glossary) or call (800) 255-4550 to request a copy. \*Deductible applies to these services.

**Standard Plan Name:** BCBS-EPO-X-NONSTANDARD-SILVER-X-BASE(MD15343) BCBS-RxHIXNS-0-1250-x-5-0.40-0.60-x-P(RX16178) CY 1014721