**Point of Service plan (POS) Open Access Plan**

Coverage Period Begins: 01/01/2016

Coverage For: UVM  Plan Type: POS

### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why this matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0 individual / $0 family preferred provider. $500 individual / $1,000 family non-preferred provider. Co-insurance and co-payments do not count towards the deductible. Preferred services do not apply to the non-preferred deductible. Does not apply to non-preferred preventive mammography screenings. *Deductible applies to these services. Does not apply to prescription drugs.</td>
<td>See the chart starting on page 2 for your costs for services this plan covers. The plan pays benefits when an individual or the family meets the deductible. Your accumulators, such as deductibles, out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2016 through 12/31/2016.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $100 durable medical equipment and supplies deductible. $100 individual / $300 family prescription drug (retail only) deductible.</td>
<td>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.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. $6,600 individual / $13,200 family preferred provider. $2,500 individual / $5,000 family non-preferred provider. Prescription drugs are limited to $1,300 individual / $2,600 family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of Participating providers see <a href="http://www.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</a> or call (800) 255-4550.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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SNO/BPN: 1019596 QS31
Point of Service plan (POS) Open Access Plan

Coverage Period Begins: 01/01/2016
Coverage For: UVM Plan Type: POS

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn't cover?</td>
<td>Yes.</td>
<td>See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

- **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.

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

- **Plan Type:** POS
- **Coverage Period:** Begins 01/01/2016
- **Coverage For:** UVM

#### Co-payments

- **Primary care visit to treat an injury or illness:**
  - **Preferred Provider:** $10 co-payment per visit for primary care physician and mental health / substance abuse
  - **Non-Preferred Provider:** 30% co-insurance* for primary care physician and mental health / substance abuse
  - Limitations & Exceptions: Some services require prior approval. For clarification on mental health services visit www.bcbsvt.com/mental-health-primary-care.

- **Specialist visit:**
  - **Preferred Provider:** $20 co-payment per visit
  - **Non-Preferred Provider:** 30% co-insurance*
  - Limitations & Exceptions: Some services require prior approval.

- **Other practitioner office visit:**
  - **Preferred Provider:** $20 co-payment per visit for chiropractic care, nutritional counseling, outpatient physical, speech, and occupational therapy
  - **Non-Preferred Provider:** 30% co-insurance* for outpatient physical, speech, and occupational therapy; chiropractic care and nutritional counseling not covered
  - Limitations & Exceptions: Some services require prior approval. Frequency limits apply.

- **Preventive care / Screening / Immunization:**
  - **Preferred Provider:** No charge
  - **Non-Preferred Provider:** 30% co-insurance*
  - Limitations & Exceptions: For clarification on preventive services visit www.bcbsvt.com/preventive.

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**SNO/BPN:** 1019596 QS31
## Summary of Benefits and Coverage:

### What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use a</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Preferred Provider</td>
<td>Non-Preferred Provider</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge for office-based and outpatient hospital</td>
<td>30% co-insurance* for office-based and outpatient hospital</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>30% co-insurance*</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition. More information about <a href="#">prescription drug coverage</a> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a>.</td>
<td>Generic drugs</td>
<td>$100 deductible, then $5 co-payment / $10 co-payment</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$100 deductible, then $20 co-payment / $40 co-payment</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$100 deductible, then $40 co-payment / $80 co-payment</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Wellness drugs</td>
<td>Wellness prescription drugs process the same as any other prescription.</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100 co-payment per visit</td>
<td>30% co-insurance*</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>30% co-insurance*</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$50 co-payment per visit for facility services; no charge for physician services</td>
<td>$50 co-payment per visit for facility services; no charge for physician services</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$50 co-payment per member per day</td>
<td>$50 co-payment per member per day</td>
</tr>
</tbody>
</table>

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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred Provider</td>
<td>Non-Preferred Provider</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Urgent care</td>
<td>$20 co-payment per visit</td>
<td>$20 co-payment per visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250 co-payment per admission (limited to three co-payments per family)</td>
<td>30% co-insurance*</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>30% co-insurance*</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>No charge</td>
<td>30% co-insurance*</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>No charge</td>
<td>30% co-insurance*</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>No charge</td>
<td>30% co-insurance*</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>No charge</td>
<td>30% co-insurance*</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$10 co-payment (one co-payment covers all routine maternity office visits)</td>
<td>30% co-insurance*</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$250 co-payment per admission (limited to three co-payments per family)</td>
<td>30% co-insurance*</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge home health care; private duty nursing $20 co-payment per visit</td>
<td>30% co-insurance*</td>
</tr>
</tbody>
</table>

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**SNO/BPN**: 1019596 QS31
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use a Preferred Provider</th>
<th>Your cost if you use a Non-Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>$250 co-payment per visit (limited to three co-payments per family); no charge cardiac / pulmonary services</td>
<td>Not covered</td>
<td>Inpatient rehabilitation services require prior approval.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$250 co-payment per admission (limited to three co-payments per family)</td>
<td>Not covered</td>
<td>Requires prior approval.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care (facility)</td>
<td>$250 co-payment per admission (limited to three co-payments per family)</td>
<td>Not covered</td>
<td>Requires prior approval.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment (including supplies)</td>
<td>$100 individual/$300 two-person and family deductible, then 20% co-insurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice</td>
<td>No charge</td>
<td>30% co-insurance*</td>
<td>None</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>$20 co-payment per child exam; $20 co-payment per adult exam</td>
<td>We pay up to our allowed price less your $20 co-payment</td>
<td>One routine exam per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

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**SNO/BPN:** 1019596 QS31
### 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
- Weight loss programs
- Cosmetic Surgery (except with prior approval for reconstruction)
- Long-term care
- Dental care (child and adult)
- Routine foot care (except for treatment of diabetes)

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

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

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**SNO/BPN:** 1019596 QS31
Point of Service plan (POS) Open Access Plan

$10 PCP/$20 Specialist co-payment, $250 co-payment Inpatient/$100 Outpatient
Pharmacy: $100 deductible (retail only), $5 co-payment/$20 co-payment/$40 co-payment

Coverage Period Begins: 01/01/2016

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

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, or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or 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.

- 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, kwiijigo holne' (800) 255-4550.

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SNO/BPN: 1019596 QS31
### 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 protection a sample patient might get if they are covered under different plans.

#### Having a baby (normal delivery)
- **Amount owed to providers:** $7,540
- **Plan Pays:** $7,110
- **Patient pays:** $430

#### 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

**Total:** $7,540

#### Patient pays:
- Deductibles: $20
- Co-pays: $260
- Coinsurance: $0
- Limits or exclusions: $150

**Total:** $430

#### Managing type 2 diabetes (routine maintenance of a well-controlled condition)
- **Amount owed to providers:** $5,400
- **Plan Pays:** $4,490
- **Patient pays:** $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

**Total:** $5,400

#### Patient pays:
- Deductibles: $200
- Co-pays: $400
- Coinsurance: $230
- Limits or exclusions: $80

**Total:** $910

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**SNO/BPN:** 1019596 QS31
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?

 שעברו. が出典されているとは、治療の実際の条件が異なるため、あなたの状態に応じてさまざまな要素があります。

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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Custom Summary Name:  BCBS-POS-x-6600-x-x-10-20-50-50-250-100-ACA-LARG (MD19395)_BCBS-Rx-100-1300-x-5-20-40-2-x-P(RX20995) wBERACA CY 1019596 QS31

Template Name:  MedGroup-2-Network-012016