Consumer Directed Health Plan (CDHP) - Comprehensive

Coverage Period Begins: 07/01/2014
Coverage For: UVM  Plan Type: CDHP

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/comp_cert or by calling (800) 255-4550.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$1,500 individual / $3,000 family. Co-insurance and co-payments do not apply to the deductible. Does not apply to preventive services. *Deductible applies to these services. This benefit combines your prescription drug and medical deductibles.</td>
<td>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. For a family contract, the family deductible must be met before the plan pays benefits. 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: 01/01/2014 through 12/31/2014.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>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.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. $1,500 individual / $3,000 family. Prescription drugs are limited to $1,250 individual / $2,500 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>
<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>
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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.

<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>Participating Provider</td>
<td>Non-Participating Provider</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge* for primary care physician and mental health / substance abuse</td>
<td>No charge* for primary care physician and mental health / substance abuse</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge*</td>
<td>No charge*</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>No charge* for chiropractic care, nutritional counseling, outpatient physical, speech, and occupational therapy</td>
<td>No charge* for outpatient physical, speech, and occupational therapy; chiropractic care and nutritional counseling not covered</td>
</tr>
<tr>
<td>Preventive care / Screening / Immunization</td>
<td>Preventive care / Screening / Immunization</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge* for office-based and outpatient hospital</td>
<td>No charge* for office-based and outpatient hospital</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge*</td>
<td>No charge*</td>
</tr>
</tbody>
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## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

### Common Medical Event

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<td>Non-Participating Provider</td>
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</table>

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

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

- **Generic drugs**
  - Participating Provider: No charge*
  - Non-Participating Provider: Not covered
  - **Limitations & Exceptions**: Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval.

- **Preferred brand drugs**
  - Participating Provider: No charge*
  - Non-Participating Provider: Not covered
  - **Limitations & Exceptions**: Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval.

- **Non-preferred brand drugs**
  - Participating Provider: No charge*
  - Non-Participating Provider: Not covered
  - **Limitations & Exceptions**: Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval.

- **Wellness drugs**
  - Participating Provider: Wellness prescription drugs process the same as any other prescription.
  - Non-Participating Provider: Not covered
  - **Limitations & Exceptions**: Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval.

### If you have outpatient surgery

- **Facility fee (e.g., ambulatory surgery center)**
  - Participating Provider: No charge*
  - Non-Participating Provider: No charge*
  - **Limitations & Exceptions**: Some services require prior approval.

- **Physician/surgeon fees**
  - Participating Provider: No charge*
  - Non-Participating Provider: No charge*
  - **Limitations & Exceptions**: Some services require prior approval.

### If you need immediate medical attention

- **Emergency room services**
  - Participating Provider: No charge* for facility and physician services
  - Non-Participating Provider: No charge* for facility and physician services
  - **Limitations & Exceptions**: Must meet emergency criteria.

- **Emergency medical transportation**
  - Participating Provider: No charge*
  - Non-Participating Provider: No charge*
  - **Limitations & Exceptions**: Must meet emergency criteria.

### If you have a hospital stay

- **Facility fee (e.g., hospital room)**
  - Participating Provider: No charge*
  - Non-Participating Provider: No charge*
  - **Limitations & Exceptions**: Out-of-state inpatient care requires prior approval.

- **Physician/surgeon fee**
  - Participating Provider: No charge*
  - Non-Participating Provider: No charge*
  - **Limitations & Exceptions**: Some services require prior approval.

### If you have mental health, behavioral health, or substance abuse needs

- **Mental/Behavioral health outpatient services**
  - Participating Provider: No charge*
  - Non-Participating Provider: No charge*
  - **Limitations & Exceptions**: Some services require prior approval.

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### SNO/BPN:

1016551  WZ26, WZ27
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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<th>Your cost if you use a</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health inpatient services</td>
<td>Participating Provider: No charge*</td>
<td>Non-Participating Provider: No charge*</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>Participating Provider: No charge*</td>
<td>Non-Participating Provider: No charge*</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>Participating Provider: No charge*</td>
<td>Non-Participating Provider: No charge*</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>Participating Provider: No charge</td>
<td>Non-Participating Provider: No charge*</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>Participating Provider: No charge*</td>
<td>Non-Participating Provider: No charge*</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>Participating Provider: No charge*</td>
<td>Non-Participating Provider: No charge*</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Participating Provider: No charge*</td>
<td>Non-Participating Provider: Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Participating Provider: No charge* for inpatient services</td>
<td>Non-Participating Provider: Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care (facility)</td>
<td>Participating Provider: No charge*</td>
<td>Non-Participating Provider: Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment (including supplies)</td>
<td>Participating Provider: No charge*</td>
<td>Non-Participating Provider: No charge*</td>
</tr>
<tr>
<td></td>
<td>Hospice</td>
<td>Participating Provider: No charge*</td>
<td>Non-Participating Provider: No charge*</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Eye exam</td>
<td>Participating Provider: Not covered</td>
<td>Non-Participating Provider: Not covered</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Participating Provider: Not covered</td>
<td>Non-Participating Provider: Not covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Participating Provider: Not covered</td>
<td>Non-Participating Provider: Not covered</td>
</tr>
</tbody>
</table>

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**SNO/BPN**: 1016551 WZ26, WZ27
### Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover</th>
<th>Cosmetically Surgery (except with prior approval for reconstruction)</th>
<th>Dental care (child and adult)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Long-term care</td>
<td>Routine eye care</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>Weight loss programs</td>
<td></td>
</tr>
<tr>
<td>Routine foot care (except for treatment of diabetes)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services</th>
<th>Bariatric Surgery</th>
<th>Chiropractic Care (requires prior approval after 12 visits)</th>
<th>Infertility Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-emergency care when traveling outside the U.S. (<a href="http://www.bcbsvt.com/coveragewhiletraveling">www.bcbsvt.com/coveragewhiletraveling</a>)</td>
<td>Private-duty nursing (covered up to 14 hours per plan year)</td>
<td></td>
</tr>
</tbody>
</table>

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SNO/BPN: 1016551 WZ26, WZ27
Consumer Directed Health Plan (CDHP) - Comprehensive

$1,500/$3,000 deductible, 0% co-insurance

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, 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 protection a sample patient might get if they are covered under different plans.

#### Having a baby (normal delivery)

<table>
<thead>
<tr>
<th>Amount owed to providers:</th>
<th>$7,540</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Pays:</strong></td>
<td>$5,890</td>
</tr>
<tr>
<td><strong>Patient pays:</strong></td>
<td>$1,650</td>
</tr>
</tbody>
</table>

**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: $1,500
- Co-pays: $0
- Coinsurance: $0
- Limits or exclusions: $150

**Total:** $1,650

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

<table>
<thead>
<tr>
<th>Amount owed to providers:</th>
<th>$5,400</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Pays:</strong></td>
<td>$3,820</td>
</tr>
<tr>
<td><strong>Patient pays:</strong></td>
<td>$1,580</td>
</tr>
</tbody>
</table>

**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: $1,500
- Co-pays: $0
- Coinsurance: $0
- Limits or exclusions: $80

**Total:** $1,580

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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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**Custom Summary Name**: BCBS-CDHP-1500-1500-0%-AGG-x-x-x-x-x-x-ACA-LARG (MD15780)_BCBSC-Rx-C0%-1250-x-0-0-0-0-x-P(RX15855)_Coverage-012014-12312014(C15340)_BER wBERACA CY 1016551 WZ26, WZ27

**Template Name**: MedGroup-2-Network-012014