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/planj_cert or www.bcbsvt.com/planj_rider or by calling (800) 255-4550.

### Important Questions | Answers | Why this matters:
--- | --- | ---
What is the overall deductible? | $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 deductibles for specific services? | Yes. $100 individual up to a maximum of three member deductibles per family for emergency medical transport, durable medical equipment and supplies, and private duty nursing. $100 individual/$300 family prescription drug (retail only) deductible. | 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 out-of-pocket limit on my expenses? | Yes. $500 per individual. Prescription drugs are limited to $750 individual/two-person/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 out-of-pocket limit? | Premiums, balance-billed charges 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 network of providers? | Yes. For a list of Participating providers see www.bcbsvt.com/findadoctor 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 specialist? | 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

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

#### Co-insurance

- **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>Participating Provider</th>
<th>Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<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>$10 co-payment per visit for primary care physician; no charge for mental health / substance abuse</td>
<td>$10 co-payment per visit for primary care physician; no charge for mental health / substance abuse</td>
<td>Some services require prior approval. For clarification on mental health services visit <a href="http://www.bcbsvt.com/mental-health-primary">www.bcbsvt.com/mental-health-primary</a> care.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$10 co-payment per visit</td>
<td>$10 co-payment per visit</td>
<td>Some services require prior approval.</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$10 co-payment per visit for chiropractic care, nutritional counseling; no charge 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>
<td>Some services require prior approval. Frequency limits apply.</td>
</tr>
<tr>
<td>Preventive care / Screening / Immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>For clarification on preventive services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a>.</td>
<td></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>
<td>Some services require prior approval.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>No charge</td>
<td>Most services require prior approval.</td>
</tr>
</tbody>
</table>

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## 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>Participating Provider</td>
<td>Non-Participating Provider</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition. More information about prescription drug coverage is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a>.</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>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>No charge for facility services; $10 co-payment per visit for physician services</td>
<td>No charge for facility services; $10 co-payment per visit for physician services</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$100 individual/$300 family deductible, then 20% coinsurance</td>
<td>$100 individual/$300 family deductible, then 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$10 co-payment per visit</td>
<td>$10 co-payment per visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>No charge</td>
</tr>
</tbody>
</table>

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

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<th>Limitations &amp; Exceptions</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Participating Provider</td>
<td>Non-Participating Provider</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>No charge</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge for home health services; $100 individual/$300 family deductible, then 20% co-insurance</td>
<td>No charge for home health services; $100 individual/$300 family deductible, then 20% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge inpatient and cardiac / pulmonary services</td>
<td>No charge inpatient; cardiac / pulmonary services not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge for inpatient services</td>
<td>No charge for inpatient services</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care (facility)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment (including supplies)</td>
<td>$100 individual/$300 family deductible, then 20% coinsurance</td>
<td>$100 individual/$300 family deductible then 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice</td>
<td>No charge</td>
<td>No charge</td>
</tr>
</tbody>
</table>

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**SNO/BPN:** 1018180 /
**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider</th>
<th>Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover**

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

**Other Covered Services**

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

**Questions**: Call (800) 255-4550 or visit us at www.bcbsvt.com/planj_cert or www.bcbsvt.com/planj_rider. 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 or call (800) 255-4550 to request a copy.
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.
**Covered Period Begins:** 01/01/2015

**Coverage For:** UVM  
**Plan Type:** Indemnity

### 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.

**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)

<table>
<thead>
<tr>
<th>Amount owed to providers:</th>
<th>$7,540</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Pays:</strong></td>
<td>$7,370</td>
</tr>
<tr>
<td><strong>Patient pays:</strong></td>
<td>$170</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 $20
- Co-pays $0
- Coinsurance $0
- Limits or exclusions $150

**Total** $170

---

### 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>$4,820</td>
</tr>
<tr>
<td><strong>Patient pays:</strong></td>
<td>$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 $200
- Co-pays $180
- Coinsurance $120
- Limits or exclusions $80

**Total** $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.