**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**
**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.cbabluevt.com** or call **1-888-222-9206**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call **1-888-222-9206** to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$5,950** individual / **$11,900** family for In-Network providers. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.<br>If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. BlueCard® preventive care and office visits are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.. |
| **Are there other deductibles for specific services?** | Yes. **$150** per individual for prescription drug coverage. | 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. |
| **What is the out-of-pocket limit for this plan?** | **$8,050** individual / **$16,100** family for In-Network providers. | The out-of-pocket limit is the most you could pay in a year for covered services.<br>If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing 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. . |
| **Will you pay less if you use a network provider?** | Yes. See **www.cbabluevt.com** or call **1-888-222-9206** for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).<br>Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copay/visit | Not covered | ——————none—————— |
| | Specialist visit | $50 copay/visit | Not covered | ——————none—————— |
| | Preventive care/screening/ immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible | Not covered | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | Not covered | ——————none—————— |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.smithrx.com. | Generic drugs | Rx Deductible; then: $5 copay/prescription (retail) $10 copay/prescription (mail order) | Not covered | Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).<br><br>Prescription Drug Deductible: $150 per member<br><br>All prescribed FDA approved contraceptive methods for women are covered at 100% when received from a participating pharmacy. Generic oral contraceptives for women are covered at 100%. The brand version will be covered at 100% when received from a participating pharmacy only if medically necessary or a generic equivalent is not available. |
| | Preferred brand drugs | Rx Deductible; then: $35 copay/prescription (retail) $70 copay/prescription (mail order) | Not covered | |
| | Non-preferred brand drugs | Rx Deductible; then: $75 copay/prescription (retail) $150 copay/prescription (mail order) | Not covered | |
| | Specialty drugs | Applicable copayment after Rx deductible | Not covered | Limited to a 30-day supply. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | Not covered | ——————none—————— |
| | Physician/surgeon fees | 20% coinsurance after deductible | Not covered | ——————none—————— |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance after deductible | 20% coinsurance after deductible | ——————none—————— |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | ——————none—————— |
| | Urgent care | 20% coinsurance after deductible | 20% coinsurance after deductible | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | Not covered | Pre-certification is required in order to avoid a reduction in benefits. |
| | Physician/surgeon fees | 20% coinsurance after deductible | Not covered | ——————none—————— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office: $20 copay/visit<br>Other: 20% coinsurance after deductible | Not covered | ——————none—————— |
| | Inpatient services | 20% coinsurance after deductible | Not covered | Pre-certification is required in order to avoid a reduction in benefits. |
| **If you are pregnant** | Office visits | No charge | Not covered | Cost sharing does not apply for preventive services.<br>Depending on the type of service, a copayment, coinsurance, or deductible may apply.<br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance after deductible | Not covered | ——————none—————— |
| | Childbirth/delivery facility services | 20% coinsurance after deductible | Not covered | Pre-certification is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid a reduction in benefits. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance after deductible | Not covered | ——————none—————— |
| | Rehabilitation services | 20% coinsurance after deductible | Not covered | Outpatient physical, speech, and occupational therapy are limited to a combined 30 visits per calendar year. Services for autism spectrum disorders are limited to a separate 30 combined visits per calendar year. Pre-certification is required for inpatient in order to avoid a reduction in benefits. |
| | Habilitation services | 20% coinsurance after deductible | Not covered | Outpatient physical, speech, and occupational therapy are limited to a combined 30 visits per calendar year. Services for autism spectrum disorders are limited to a separate 30 combined visits per calendar year. |
| | Skilled nursing care | 20% coinsurance after deductible | Not covered | Pre-certification is required in order to avoid a reduction in benefits. |
| | Durable medical equipment | 20% coinsurance after deductible<br>Breast Pump: No charge | Not covered | Pre-certification is required for amounts over $3,500. |
| | Hospice services | 20% coinsurance after deductible | Not covered | ——————none—————— |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Not covered | Coverage limited to one exam per calendar year up to age 19. |
| | Children's glasses | No charge | Not covered | Coverage limited to one pair of frames and lenses for prescription glasses or one pair of equivalent contact lenses per calendar year up to age 19. |
| | Children's dental check-up | No charge | Not covered | Coverage limited to two exams per calendar year up to age 19. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (age 19 and over)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (age 19 and over)
- Routine foot care (except for treatment of diabetes)
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric surgery
- Chiropractic care (limited to 12 visits per calendar year)
- Non-emergency care when traveling outside the U.S
- Private-duty nursing (limited to 14 hours per calendar year)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at **1-888-222-9206.** You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at **1-888-222-9206.** You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al **1-888-222-9206.**

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-222-9206.**

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **1-888-222-9206.**

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-888-222-9206.**

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $5,950 |
| Specialist *copayment* | $50 |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $6,000 |
| Copayments | $0 |
| Coinsurance | $1,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,360** |

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

| | |
|---|---|
| The plan's overall deductible | $5,950 |
| Specialist *copayment* | $50 |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education*)
Diagnostic test (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,220** |

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

| | |
|---|---|
| The plan's overall deductible | $5,950 |
| Specialist *copayment* | $50 |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**This EXAMPLE event includes services like:**
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,500 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,700** |