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

Important Questions	Answers	Why this matters:
What is the overall **deductible**?	$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.	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: 01/01/2017 through 12/31/2017. We apply any portion of your deductible that you pay for services occurring after September 30 each plan year towards your next year's deductible as well.
Are there other **deductibles** for specific services?	Yes. $100 durable medical equipment and supplies 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. $6,350 individual / $12,700 family preferred provider. $12,700 individual / $25,400 family non-preferred provider. Prescription drugs: $600 individual / $1,200 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.

Questions: Call (800) 255-4550 or visit us at www.bcbsvt.com/vhp_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 or call (800) 255-4550 to request a copy.

- **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
		Preferred Provider	Non-Preferred Provider	
If you visit a health care **provider's** 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 www.bcbsvt.com/mental-health-primary-care.
	Specialist visit	$25 co-payment per visit	30% co-insurance*	Some services require prior approval.
	Other practitioner office visit	$25 co-payment per visit for chiropractic care, nutritional counseling, outpatient physical, speech and occupational therapy	30% co-insurance* for outpatient physical, speech and occupational therapy; chiropractic care and nutritional counseling not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	30% co-insurance*	For clarification on preventive services visit www.bcbsvt.com/preventive.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for office-based and outpatient hospital	30% co-insurance* for office-based and outpatient hospital	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	No charge	30% co-insurance*	Most services require prior approval.

Questions: Call (800) 255-4550 or visit us at www.bcbsvt.com/vhp_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 or call (800) 255-4550 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a Preferred Provider	Your cost if you use a Non-Preferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is at www.bcbsvt.com/rxcenter.	Generic drugs	$5 co-payment / $10 co-payment	Not covered	All generic and brand diabetic prescription drugs are covered at 100%. Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	$20 co-payment / $40 co-payment	Not covered	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	$45 co-payment / $90 co-payment	Not covered	Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	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)	No charge	30% co-insurance*	Some services require prior approval.
	Physician/surgeon fees	No charge	30% co-insurance*	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	$50 co-payment per member per day	$50 co-payment per member per day	Must meet emergency criteria.
	Urgent care	$25 co-payment per visit	$25 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% co-insurance*	Out-of-state inpatient care requires prior approval.
	Physician/surgeon fee	No charge	30% co-insurance*	Some services require prior approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	30% co-insurance*	Some services require prior approval.
	Mental/Behavioral health inpatient services	No charge	30% co-insurance*	Includes facility and physician fees. Requires prior approval.

Questions: Call (800) 255-4550 or visit us at www.bcbsvt.com/vhp_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 or call (800) 255-4550 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a Preferred Provider	Your cost if you use a Non-Preferred Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder outpatient services	No charge	30% co-insurance*	Some services require prior approval.
	Substance use disorder inpatient services	No charge	30% co-insurance*	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	30% co-insurance*	None
	Delivery and all inpatient services	No charge	30% co-insurance*	Out-of-state inpatient care requires prior approval.
If you need help recovering or have other special health needs	Home health care	No charge for home health care; $25 co-payment per visit private duty nursing	30% co-insurance*	Home infusion therapy requires prior approval. Frequency limits apply.
	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. Frequency limits apply.
	Skilled nursing care (facility)	No charge	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	20% co-insurance*	Not covered	May require prior approval. Diabetic supplies are covered at 100%.
	Hospice	No charge	30% co-insurance*	None
If your child needs dental or eye care	Eye exam	$20 co-payment per child exam; $20 co-payment per adult exam	We pay up to our allowed price less your $20 co-payment	One routine exam per calendar year.
	Glasses	Not covered	Not covered	None
	Dental check-up	Not covered	Not covered	None

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 (child and adult)
- Hearing aids
- Long-term care
- Routine foot care (except for treatment of diabetes)
- Weight loss programs

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

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

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?<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

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.**

Questions: Call (800) 255-4550 or visit us at www.bcbsvt.com/vhp_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 or call (800) 255-4550 to request a copy.

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

Questions: Call (800) 255-4550 or visit us at www.bcbsvt.com/vhp_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 or call (800) 255-4550 to request a copy.

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)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,380
- **Patient pays:** $160

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	$0
Co-pays	$10
Coinsurance	$0
Limits or exclusions	$150
Total	$160

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,540
- **Patient pays:** $860

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	$100
Co-pays	$450
Coinsurance	$230
Limits or exclusions	$80
Total	$860

Questions: Call (800) 255-4550 or visit us at www.bcbsvt.com/vhp_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 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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex.

BCBSVT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

BCBSVT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394
TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

For free language-assistance services, call (800) 247-2583.

ARABIC

للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583.

GERMAN

Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

SPANISH

Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

FRENCH

Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

ITALIAN

Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

JAPANESE

無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI

नि:शुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN

Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)

Za besplatnu uslugu prevođenja, pozovite na broj (800) 247-2583.

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

TAGALOG

Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

VIETNAMESE

Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.

CHINESE

如需免費語言協助服務，請致電(800) 247-2583。

CUSHITE (OROMO)

Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.