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.dol.gov/ebsa/healthreform or call **1-888-222-9206** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500** individual / **$3,000** family for In-Network providers and **$3,000** individual / **$6,000** family for Out-of-Network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, physician office visit and urgent care services 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. **$50** individual / **$100** family for In-Network prescription drug coverage. There are no other specific deductibles.	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?	**$2,750** individual / **$5,500** family for In-Network providers and **$5,500** individual / **$11,000** family for Out-of-Network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. 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, pre-certification penalties 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). Or 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
		In-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	40% coinsurance after deductible	——————none——————
	Specialist visit	$30 copay/visit	40% coinsurance after deductible	——————none——————
	Preventive care/screening/ immunization	No charge	40% coinsurance after deductible	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. See plan document for frequency limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.magellanrx.com	Generic drugs	$20 copay/prescription (30-day retail); $60 copay/prescription (90-day retail); $40 copay/prescription (mail order) after deductible	Not covered	Covers up to a 90-day supply (retail and mail order prescriptions). 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	$45 copay/prescription (30-day retail); $135 copay/prescription (90-day retail); $90 copay/prescription (mail order) after deductible	Not covered	
	Non-preferred brand drugs	$75 copay/prescription (30-day retail); $225 copay/prescription (90-day retail); $150 copay/prescription (mail order) after deductible	Not covered	
	Specialty drugs	20% coinsurance up to a maximum of $150 copay/prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	$150 copay/visit then 20% coinsurance after in-network deductible		Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance after in-network deductible		——————none——————
	Urgent care	$40 copay/visit	40% coinsurance after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/confinement then 20% coinsurance after deductible	$300 copay/confinement then 40% coinsurance after deductible	Pre-certification is required.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	40% coinsurance after deductible	——————none——————
	Inpatient services	$300 copay/confinement then 20% coinsurance after deductible	$300 copay/confinement then 40% coinsurance after deductible	Pre-certification is required.
If you are pregnant	Office visits	$20 copay/visit PCP or $30 copay/visit Specialist applies to first visit to confirm pregnancy, then no charge thereafter for prenatal care 20% coinsurance after deductible for postnatal care	40% coinsurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Childbirth/delivery facility services	$300 copay/confinement then 20% coinsurance after deductible	$300 copay/confinement then 40% coinsurance after deductible	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	40% coinsurance after deductible	Limited to 25 visits per plan year.
	Rehabilitation services	20% coinsurance after deductible for outpatient $300 copay/confinement then 20% coinsurance after deductible for inpatient	40% coinsurance after deductible for outpatient $300 copay/confinement then 40% coinsurance after deductible for inpatient	Outpatient physical, occupational and speech therapy is limited to 30 visits per plan year combined. Pre-certification is required for inpatient services.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to 30 visits per plan year combined.
	Skilled nursing care	$300 copay/confinement then 20% coinsurance after deductible	$300 copay/confinement then 40% coinsurance after deductible	Limited to 100 days per plan year. Pre-certification is required.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 6 months per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance after deductible	Eye exams are included in the preventive benefit. See plan document for frequency limitations.
	Children's glasses	Not covered		Not covered.
	Children's dental check-up	Not covered		Not covered.

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids (except due to a birth defect, trauma or illness)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

- Chiropractic care (limited to $1,000 per plan year)
- Private-duty nursing
- Routine eye care (Adult)

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. Additionally, a consumer assistance program can help you file your appeal. Contact Vermont Division of Financial Regulation at 89 Main st., Montpelier, VT 05620-3101 or call 800-964-1784. A list of states with Consumer Assistance Programs is available at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/

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	$1,500
Specialist copayment	$30
Hospital (facility) copayment	$300
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	$1,500
Copayments	$300
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,660**

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

The plan's overall deductible	$1,500
Specialist copayment	$30
Hospital (facility) copayment	$300
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

The plan's overall deductible	$1,500
Specialist copayment	$30
Hospital (facility) copayment	$300
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	$1,500
Copayments	$90
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,790**