

 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](http://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](http://www.dol.gov/ebsa/healthreform) or call 1-888-222-9206 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><b>\$500</b> individual / <b>\$1,000</b> family for <a href="#">In-Network providers</a> and <b>\$1,000</b> individual / <b>\$2,000</b> family for <a href="#">Out-of-Network providers</a>.</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <a href="#">Preventive care</a>, physician office visit and urgent care services are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>Yes. <b>\$50</b> individual / <b>\$100</b> family for In-Network prescription drug coverage. There are no other specific <a href="#">deductibles</a>.</p>	<p>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><b>\$1,050</b> individual / <b>\$2,100</b> family for <a href="#">In-Network providers</a> and <b>\$2,100</b> individual / <b>\$4,200</b> family for <a href="#">Out-of-Network providers</a>.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><a href="#">Premiums</a>, <a href="#">balance-billing charges</a>, pre-certification penalties and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://www.cbabluevt.com">www.cbabluevt.com</a> or call 1-888-222-9206 for a list of <a href="#">network providers</a>.</p>	<p>This <a href="#">plan</a> uses a provider <a href="#">network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Or Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>



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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 copay/visit	40% coinsurance after deductible	—————none—————
	<a href="#">Specialist</a> visit	\$30 copay/visit	40% coinsurance after deductible	—————none—————
	<a href="#">Preventive care/screening/immunization</a>	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (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—————
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.magellanrx.com">www.magellanrx.com</a>	Generic drugs	\$10 copay/prescription (30-day retail); \$30 copay/prescription (90-day retail); \$20 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	\$30 copay/prescription (30-day retail); \$90 copay/prescription (90-day retail); \$60 copay/prescription (mail order) after deductible	Not covered	
	Non-preferred brand drugs	\$55 copay/prescription (30-day retail); \$165 copay/prescription (90-day retail); \$110 copay/prescription (mail order) after deductible	Not covered	
	<a href="#">Specialty drugs</a>	20% coinsurance up to a maximum of \$150 copay/prescription	Not covered	
<b>If you have outpatient surgery</b>	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	<a href="#">Emergency room care</a>	\$150 copay/visit then 20% coinsurance after in-network deductible		Copayment waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% coinsurance after in-network deductible		—————none—————
	<a href="#">Urgent care</a>	\$40 copay/visit	40% coinsurance after deductible	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 copay/confinement then 20% coinsurance after deductible	\$200 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	\$200 copay/confinement then 20% coinsurance after deductible	\$200 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	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of service, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> 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	\$200 copay/confinement then 20% coinsurance after deductible	\$200 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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 25 visits per plan year.
	<a href="#">Rehabilitation services</a>	20% coinsurance after deductible for outpatient \$200 copay/confinement then 20% coinsurance after deductible for inpatient	40% coinsurance after deductible for outpatient \$200 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.
	<a href="#">Habilitation services</a>	20% coinsurance after deductible	40% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to 30 visits per plan year combined.
	<a href="#">Skilled nursing care</a>	\$200 copay/confinement then 20% coinsurance after deductible	\$200 copay/confinement then 40% coinsurance after deductible	Limited to 100 days per plan year. Pre-certification is required.
	<a href="#">Durable medical equipment</a>	20% coinsurance after deductible	40% coinsurance after deductible	—————none—————
	<a href="#">Hospice services</a>	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 6 months per lifetime.
<b>If your child needs dental or eye care</b>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids (except due to a birth defect, trauma or illness)</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Chiropractic care (limited to \$1,000 per plan year)</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> </ul>

**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](http://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](http://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](http://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](http://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](http://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, kwijigo holne' **1-888-222-9206**

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

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a> copayment	\$30
■ Hospital (facility) copayment	\$200
■ 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$600
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,110</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a> copayment	\$30
■ Hospital (facility) copayment	\$200
■ 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,070</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a> copayment	\$30
■ Hospital (facility) copayment	\$200
■ 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,000</b>