

# National Franchisee Association – Bronze Basic

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO



**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.cbabluevt.com](http://www.cbabluevt.com) or by calling 1-888-222-9206.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$5,500</b> individual/ <b>\$11,000</b> family for In-Network and <b>\$11,000</b> individual/ <b>\$22,000</b> family for Out-of-Network. Doesn't apply to In-Network preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. <b>\$200</b> individual/ <b>\$400</b> family for In-Network prescription drug coverage. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>\$6,600</b> individual/ <b>\$13,200</b> family for In-Network, <b>\$13,200</b> individual/ <b>\$26,400</b> family for Out-of-Network.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, pre-certification penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of providers?	Yes. See <a href="http://www.cbabluevt.com">www.cbabluevt.com</a> or call 1-888-222-9206 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge for combined total of 1 visit then 50% coinsurance after deductible	50% coinsurance after deductible	_____none_____
	Specialist visit	No charge for combined total of 1 visit then 50% coinsurance after deductible	50% coinsurance after deductible	_____none_____
	Other practitioner office visit	No charge for combined total of 1 visit then 50% coinsurance after deductible for chiropractic care	50% coinsurance after deductible for chiropractic care	Chiropractic care is limited to a maximum benefit of \$1,000 per plan year.
	Preventive care/screening/immunization	No charge	50% coinsurance after deductible	See plan document for frequency limitations.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance after deductible	50% coinsurance after deductible	_____none_____

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Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Imaging (CT/PET scans, MRIs)	50% coinsurance after deductible	50% coinsurance after deductible	Pre-admission certification must be obtained for certain procedures in order to avoid a \$500 penalty.
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.magellanrx.com">www.magellanrx.com</a> .	Generic drugs	50% coinsurance after deductible (retail and mail order)	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred Brand drugs	50% coinsurance after deductible (retail and mail order)		
	Non-Preferred Brand drugs	50% coinsurance after deductible (retail and mail order)		
	Specialty drugs	20% coinsurance up to a maximum of \$150 per prescription		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	50% coinsurance after deductible	50% coinsurance after deductible	_____none_____
	Physician/surgeon fees	50% coinsurance after deductible	50% coinsurance after deductible	_____none_____
<b>If you need immediate medical attention</b>	Emergency room services	\$350/visit then 50% coinsurance after in-network deductible		_____none_____
	Emergency medical transportation	50% coinsurance after in-network deductible		_____none_____
	Urgent care	No charge for combined total of 1 visit then 50% coinsurance after deductible	50% coinsurance after deductible	_____none_____

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		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$400/confinement then 50% coinsurance after deductible	\$400/confinement then 50% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Physician/surgeon fee	50% coinsurance after deductible	50% coinsurance after deductible	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge for combined total of 1 visit then 50% coinsurance after deductible	50% coinsurance after deductible	_____none_____
	Mental/Behavioral health inpatient services	\$400/confinement then 50% coinsurance after deductible	\$400/confinement then 50% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Substance use disorder outpatient services	No charge for combined total of 1 visit then 50% coinsurance after deductible	50% coinsurance after deductible	_____none_____
	Substance use disorder inpatient services	\$400/confinement then 50% coinsurance after deductible	\$400/confinement then 50% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
If you are pregnant	Prenatal and postnatal care	50% coinsurance after deductible for first visit to confirm pregnancy, then no charge thereafter for prenatal care; 50% coinsurance after deductible for postnatal care	50% coinsurance after deductible	_____none_____

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		In-Network Provider	Out-of-Network Provider	
	Delivery and all inpatient services	\$400/confinement then 50% coinsurance after deductible	\$400/confinement then 50% 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 in order to avoid a \$500 penalty.
<b>If you need help recovering or have other special health needs</b>	Home health care	50% coinsurance after deductible	50% coinsurance after deductible	Limited to 25 visits per plan year.
	Rehabilitation services	Inpatient: \$400/confinement then 50% coinsurance after deductible Outpatient: 50% coinsurance after deductible	Inpatient: \$400/confinement then 50% coinsurance after deductible Outpatient: 50% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
	Habilitation services	50% coinsurance after deductible	50% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
	Skilled nursing care	\$400/confinement then 50% coinsurance after deductible	\$400/confinement then 50% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty. Limited to 100 days per plan year.
	Durable medical equipment	50% coinsurance after deductible	50% coinsurance after deductible	—————none—————
	Hospice service	50% coinsurance after deductible	50% coinsurance after deductible	Limited to 6 months per lifetime.
<b>If your child needs dental or eye care</b>	Eye exam	No charge	50% coinsurance after deductible	Eye exams are included in the preventive benefit. See plan document for frequency limitations.

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		In-Network Provider	Out-of-Network Provider	
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

## Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<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> <li>• Most covered provided outside the United States</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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing (outpatient, medically necessary)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> </ul>

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### 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 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](http://www.dol.gov/ebsa), 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).

### 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 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](http://www.dol.gov/ebsa), 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).

### 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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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## 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 \$790
- Patient pays \$6,750

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$5,520
Copays	\$400
Coinsurance	\$680
Limits or exclusions	\$150
<b>Total</b>	<b>\$6,750</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$600
- Patient pays \$4,800

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$4,170
Copays	\$0
Coinsurance	\$550
Limits or exclusions	\$80
<b>Total</b>	<b>\$4,800</b>

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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**, **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.

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# National Franchisee Association – Bronze Preferred

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Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$4,000</b> individual/ <b>\$8,000</b> family for In-Network and <b>\$8,000</b> individual/ <b>\$16,000</b> family for Out-of-Network. Doesn't apply to In-Network preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. <b>\$50</b> individual/ <b>\$100</b> family for In-Network prescription drug coverage. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>\$6,600</b> individual/ <b>\$13,200</b> family for In-Network, <b>\$13,200</b> individual/ <b>\$26,400</b> family for Out-of-Network.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, pre-certification penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of providers?	Yes. See <a href="http://www.cbabluevt.com">www.cbabluevt.com</a> or call 1-888-222-9206 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$40/visit	50% coinsurance after deductible	—————none—————
	Specialist visit	\$60/visit	50% coinsurance after deductible	—————none—————
	Other practitioner office visit	\$60/visit for chiropractic care	50% coinsurance after deductible for chiropractic care	Chiropractic care is limited to a maximum benefit of \$1,000 per plan year.
	Preventive care/screening/immunization	No charge	50% coinsurance after deductible	See plan document for frequency limitations.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible	50% coinsurance after deductible	—————none—————
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	50% coinsurance after deductible	Pre-admission certification must be obtained for certain procedures in order to avoid a \$500 penalty.

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		In-Network Provider	Out-of-Network Provider	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.magellanrx.com">www.magellanrx.com</a> .	Generic drugs	\$25/prescription (retail) and \$50/prescription (mail order) after deductible	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred Brand drugs	\$55/prescription (retail) and \$110/prescription (mail order) after deductible		
	Non-Preferred Brand drugs	\$80/prescription (retail) and \$160/prescription (mail order) after deductible		
	Specialty drugs	20% coinsurance up to a maximum of \$150 per prescription		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____
<b>If you need immediate medical attention</b>	Emergency room services	\$300/visit then 30% coinsurance after in-network deductible		_____none_____
	Emergency medical transportation	30% coinsurance after in-network deductible		_____none_____
	Urgent care	\$75/visit	50% coinsurance after deductible	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$400/confinement then 30% coinsurance after deductible	\$400/confinement then 50% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Physician/surgeon fee	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____

**Questions:** Call 1-888-222-9206 or visit us at [www.cbabluevt.com](http://www.cbabluevt.com).

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# National Franchisee Association – Bronze Preferred

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$40/visit	50% coinsurance after deductible	—————none—————
	Mental/Behavioral health inpatient services	\$400/confinement then 30% coinsurance after deductible	\$400/confinement then 50% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Substance use disorder outpatient services	\$40/visit	50% coinsurance after deductible	—————none—————
	Substance use disorder inpatient services	\$400/confinement then 30% coinsurance after deductible	\$400/confinement then 50% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
<b>If you are pregnant</b>	Prenatal and postnatal care	\$40/visit PCP or \$60/visit Specialist applies to first visit to confirm pregnancy, then no charge thereafter for prenatal care; 30% coinsurance for postnatal care	50% coinsurance after deductible	—————none—————
	Delivery and all inpatient services	\$400/confinement then 30% coinsurance after deductible	\$400/confinement then 50% 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 in order to avoid a \$500 penalty.

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# National Franchisee Association – Bronze Preferred

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need help recovering or have other special health needs</b>	Home health care	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 25 visits per plan year.
	Rehabilitation services	Inpatient: \$400/confinement then 30% coinsurance after deductible  Outpatient: 30% coinsurance after deductible	Inpatient: \$400/confinement then 50% coinsurance after deductible  Outpatient: 50% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
	Habilitation services	30% coinsurance after deductible	50% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
	Skilled nursing care	\$400/confinement then 30% coinsurance after deductible	\$400/confinement then 50% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.  Limited to 100 days per plan year.
	Durable medical equipment	30% coinsurance after deductible	50% coinsurance after deductible	—————none—————
	Hospice service	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 6 months per lifetime.
	<b>If your child needs dental or eye care</b>	Eye exam	No charge	50% coinsurance after deductible
Glasses			Not covered	Not covered.
Dental check-up			Not covered	Not covered.

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## Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<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><li>• Most coverage provided outside the United States</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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"><li>• Chiropractic care</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:

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 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](http://www.dol.gov/ebsa), 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).

### 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 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](http://www.dol.gov/ebsa), 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).

**Questions:** Call 1-888-222-9206 or visit us at [www.cbabluevt.com](http://www.cbabluevt.com).

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## 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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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## 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 \$1,990
- Patient pays \$5,550

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$4,020
Copays	\$400
Coinsurance	\$980
Limits or exclusions	\$150
<b>Total</b>	<b>\$5,550</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$620
- Patient pays \$4,780

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$4,020
Copays	\$680
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$4,780</b>

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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**, **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.

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# National Franchisee Association – Silver Basic

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO



**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.cbabluevt.com](http://www.cbabluevt.com) or by calling 1-888-222-9206.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$3,000</b> individual/ <b>\$6,000</b> family for In-Network and <b>\$6,000</b> individual/ <b>\$12,000</b> family for Out-of-Network. Doesn't apply to In-Network preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. <b>\$75</b> individual/ <b>\$150</b> family for In-Network prescription drug coverage. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>\$6,600</b> individual/ <b>\$13,200</b> family for In-Network, <b>\$13,200</b> individual/ <b>\$26,400</b> family for Out-of-Network.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, pre-certification penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of providers?	Yes. See <a href="http://www.cbabluevt.com">www.cbabluevt.com</a> or call 1-888-222-9206 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30/visit	50% coinsurance after deductible	—————none—————
	Specialist visit	\$60/visit	50% coinsurance after deductible	—————none—————
	Other practitioner office visit	\$60/visit for chiropractic care	50% coinsurance after deductible for chiropractic care	Chiropractic care is limited to a maximum benefit of \$1,000 per plan year.
	Preventive care/screening/immunization	No charge	50% coinsurance after deductible	See plan document for frequency limitations.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible	50% coinsurance after deductible	—————none—————
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	50% coinsurance after deductible	Pre-admission certification must be obtained for certain procedures in order to avoid a \$500 penalty.

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# National Franchisee Association – Silver Basic

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.magellanrx.com">www.magellanrx.com</a> .	Generic drugs	30% coinsurance after deductible (retail and mail order)	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred Brand drugs	30% coinsurance after deductible (retail and mail order)		
	Non-Preferred Brand drugs	30% coinsurance after deductible (retail and mail order)		
	Specialty drugs	20% coinsurance up to a maximum of \$150 per prescription		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____
<b>If you need immediate medical attention</b>	Emergency room services	\$250/visit then 30% coinsurance after in-network deductible		_____none_____
	Emergency medical transportation	30% coinsurance after in-network deductible		_____none_____
	Urgent care	\$75/visit	40% coinsurance after deductible	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$300/confinement then 30% coinsurance after deductible	\$300/confinement then 50% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Physician/surgeon fee	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____

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Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$30/visit	50% coinsurance after deductible	—————none—————
	Mental/Behavioral health inpatient services	\$300/confinement then 30% coinsurance after deductible	\$300/confinement then 50% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Substance use disorder outpatient services	\$30/visit	50% coinsurance after deductible	—————none—————
	Substance use disorder inpatient services	\$300/confinement then 30% coinsurance after deductible	\$300/confinement then 50% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
<b>If you are pregnant</b>	Prenatal and postnatal care	\$30/visit PCP or \$60/visit Specialist applies to first visit to confirm pregnancy, then no charge thereafter for prenatal care; 30% coinsurance after deductible for postnatal care	50% coinsurance after deductible	—————none—————
	Delivery and all inpatient services	\$300/confinement then 30% coinsurance after deductible	\$300/confinement then 50% 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 in order to avoid a \$500 penalty.

**Questions:** Call 1-888-222-9206 or visit us at [www.cbabluevt.com](http://www.cbabluevt.com).

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need help recovering or have other special health needs</b>	Home health care	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 25 visits per plan year.
	Rehabilitation services	Inpatient: \$300/confinement then 30% coinsurance after deductible  Outpatient: 30% coinsurance after deductible	Inpatient: \$300/confinement then 50% coinsurance after deductible  Outpatient: 50% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
	Habilitation services	30% coinsurance after deductible	50% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
	Skilled nursing care	\$300/confinement then 30% coinsurance after deductible	\$300/confinement then 50% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.  Limited to 100 days per plan year.
	Durable medical equipment	30% coinsurance after deductible	50% coinsurance after deductible	—————none—————
	Hospice service	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 6 months per lifetime.
	<b>If your child needs dental or eye care</b>	Eye exam	No charge	50% coinsurance after deductible
Glasses			Not covered	Not covered.
Dental check-up			Not covered	Not covered.

**Questions:** Call 1-888-222-9206 or visit us at [www.cbabluevt.com](http://www.cbabluevt.com).

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## Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<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><li>• Most coverage provided outside the United States</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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"><li>• Chiropractic care</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:

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### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$2,790
- Patient pays \$4,750

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$3,020
Copays	\$300
Coinsurance	\$1,280
Limits or exclusions	\$150
<b>Total</b>	<b>\$4,750</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$1,990
- Patient pays \$3,410

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$2,500
Copays	\$0
Coinsurance	\$830
Limits or exclusions	\$80
<b>Total</b>	<b>\$3,410</b>

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- 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.

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**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.cbabluevt.com](http://www.cbabluevt.com) or by calling 1-888-222-9206.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$2,000</b> individual/ <b>\$4,000</b> family for In-Network and <b>\$4,000</b> individual/ <b>\$8,000</b> family for Out-of-Network. Doesn't apply to In-Network preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. <b>\$50</b> individual/ <b>\$100</b> family for In-Network prescription drug coverage. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>\$6,600</b> individual/ <b>\$13,200</b> family for In-Network, <b>\$13,200</b> individual/ <b>\$26,400</b> family for Out-of-Network.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, pre-certification penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of providers?	Yes. See <a href="http://www.cbabluevt.com">www.cbabluevt.com</a> or call 1-888-222-9206 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30/visit	40% coinsurance after deductible	—————none—————
	Specialist visit	\$50/visit	40% coinsurance after deductible	—————none—————
	Other practitioner office visit	\$50/visit for chiropractic care	40% coinsurance after deductible for chiropractic care	Chiropractic care is limited to a maximum benefit of \$1,000 per plan year.
	Preventive care/screening/immunization	No charge	40% coinsurance after deductible	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	Pre-admission certification must be obtained for certain procedures in order to avoid a \$500 penalty.

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# National Franchisee Association – Silver Choice

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.magellanrx.com">www.magellanrx.com</a> .	Generic drugs	\$20/prescription (retail) and \$40/prescription (mail order) after deductible	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred Brand drugs	\$50/prescription (retail) and \$100/prescription (mail order) after deductible		
	Non-Preferred Brand drugs	\$80/prescription (retail) and \$160/prescription (mail order) after deductible		
	Specialty drugs	20% coinsurance up to a maximum of \$150 per prescription		
<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_____
<b>If you need immediate medical attention</b>	Emergency room services	\$200/visit then 20% coinsurance after in-network deductible		_____none_____
	Emergency medical transportation	20% coinsurance after in-network deductible		_____none_____
	Urgent care	\$50/visit	40% coinsurance after deductible	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$300/confinement then 20% coinsurance after deductible	\$300/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Physician/surgeon fee	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____

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Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$30/visit	40% coinsurance after deductible	—————none—————
	Mental/Behavioral health inpatient services	\$300/confinement then 20% coinsurance after deductible	\$300/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Substance use disorder outpatient services	\$30/visit	40% coinsurance after deductible	—————none—————
	Substance use disorder inpatient services	\$300/confinement then 20% coinsurance after deductible	\$300/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
<b>If you are pregnant</b>	Prenatal and postnatal care	\$30/visit PCP or \$50/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	—————none—————
	Delivery and all inpatient services	\$300/confinement then 20% coinsurance after deductible	\$300/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 in order to avoid a \$500 penalty.

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		In-Network Provider	Out-of-Network Provider	
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 25 visits per plan year.
	Rehabilitation services	Inpatient: \$300/confinement then 20% coinsurance after deductible  Outpatient: 20% coinsurance after deductible	Inpatient: \$300/confinement then 40% coinsurance after deductible  Outpatient: 40% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
	Skilled nursing care	\$300/confinement then 20% coinsurance after deductible	\$300/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.  Limited to 100 days per plan year.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	—————none—————
	Hospice service	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 6 months per lifetime.
	<b>If your child needs dental or eye care</b>	Eye exam	No charge	40% coinsurance after deductible
Glasses			Not covered	Not covered.
Dental check-up			Not covered	Not covered.

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## Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<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><li>• Most coverage provided outside the United States</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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
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Coinsurance	\$1,050
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,520</b>

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- Amount owed to providers: \$5,400
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#### Sample care costs:

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Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$2,050
Copays	\$830
Coinsurance	\$60
Limits or exclusions	\$80
<b>Total</b>	<b>\$3,020</b>

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### Does the Coverage Example predict my future expenses?

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### 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.

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**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.cbabluevt.com](http://www.cbabluevt.com) or by calling 1-888-222-9206.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$1,000</b> individual/ <b>\$2,000</b> family for In-Network and <b>\$2,000</b> individual/ <b>\$4,000</b> family for Out-of-Network. Doesn't apply to In-Network preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. <b>\$50</b> individual/ <b>\$100</b> family for In-Network prescription drug coverage. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>\$5,750</b> individual/ <b>\$11,500</b> family for In-Network, <b>\$11,500</b> individual/ <b>\$23,000</b> family for Out-of-Network.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, pre-certification penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of providers?	Yes. See <a href="http://www.cbabluevt.com">www.cbabluevt.com</a> or call 1-888-222-9206 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25/visit	40% coinsurance after deductible	—————none—————
	Specialist visit	\$45/visit	40% coinsurance after deductible	—————none—————
	Other practitioner office visit	\$45/visit for chiropractic care	40% coinsurance after deductible for chiropractic care	Chiropractic care is limited to a maximum benefit of \$1,000 per plan year.
	Preventive care/screening/immunization	No charge	40% coinsurance after deductible	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	Pre-admission certification must be obtained for certain procedures in order to avoid a \$500 penalty.

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# National Franchisee Association – Gold Basic

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.magellanrx.com">www.magellanrx.com</a> .	Generic drugs	\$20/prescription (retail) \$40/prescription (mail order) after deductible	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred Brand drugs	\$45/prescription (retail) \$90/prescription (mail order) after deductible		
	Non-Preferred Brand drugs	\$75/prescription (retail) \$150/prescription (mail order) after deductible		
	Specialty drugs	20% coinsurance up to a maximum of \$150 per prescription		
<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_____
<b>If you need immediate medical attention</b>	Emergency room services	\$200/visit then 20% coinsurance after in-network deductible		_____none_____
	Emergency medical transportation	20% coinsurance after in-network deductible		_____none_____
	Urgent care	\$45/visit	40% coinsurance after deductible	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$300/confinement then 20% coinsurance after deductible	\$300/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Physician/surgeon fee	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____

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# National Franchisee Association – Gold Basic

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$25/visit	40% coinsurance after deductible	—————none—————
	Mental/Behavioral health inpatient services	\$300/confinement then 20% coinsurance after deductible	\$300/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Substance use disorder outpatient services	\$25/visit	40% coinsurance after deductible	—————none—————
	Substance use disorder inpatient services	\$300/confinement then 20% coinsurance after deductible	\$300/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
<b>If you are pregnant</b>	Prenatal and postnatal care	\$25/visit PCP or \$45/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	—————none—————
	Delivery and all inpatient services	\$300/confinement then 20% coinsurance after deductible	\$300/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 in order to avoid a \$500 penalty.

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# National Franchisee Association – Gold Basic

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 25 visits per plan year.
	Rehabilitation services	Inpatient: \$300/confinement then 20% coinsurance after deductible  Outpatient: 20% coinsurance after deductible	Inpatient: \$300/confinement then 40% coinsurance after deductible  Outpatient: 40% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
	Skilled nursing care	\$300/confinement then 20% coinsurance after deductible	\$300/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.  Limited to 100 days per plan year.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	—————none—————
	Hospice service	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 6 months per lifetime.
	<b>If your child needs dental or eye care</b>	Eye exam	No charge	40% coinsurance after deductible
Glasses			Not covered	Not covered.
Dental check-up			Not covered	Not covered.

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## Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<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><li>• Most coverage provided outside the United States</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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"><li>• Chiropractic care</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:

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 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](http://www.dol.gov/ebsa), 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).

## 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 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](http://www.dol.gov/ebsa), 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).

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## 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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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## 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 \$4,820
- Patient pays \$2,720

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$1,020
Copays	\$300
Coinsurance	\$1,250
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,720</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$3,120
- Patient pays \$2,250

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$1,050
Copays	\$930
Coinsurance	\$190
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,250</b>

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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**, **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.

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Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$1,500</b> individual/ <b>\$3,000</b> family for In-Network and <b>\$3,000</b> individual/ <b>\$6,000</b> family for Out-of-Network. Doesn't apply to In-Network preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. <b>\$50</b> individual/ <b>\$100</b> family for In-Network prescription drug coverage. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>\$2,750</b> individual/ <b>\$5,500</b> family for In-Network, <b>\$5,500</b> individual/ <b>\$11,000</b> family for Out-of-Network.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, pre-certification penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.cbabluevt.com">www.cbabluevt.com</a> or call 1-888-222-9206 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20/visit	40% coinsurance after deductible	—————none—————
	Specialist visit	\$30/visit	40% coinsurance after deductible	—————none—————
	Other practitioner office visit	\$30/visit for chiropractic care	40% coinsurance after deductible for chiropractic care	Chiropractic care is limited to a maximum benefit of \$1,000 per plan year.
	Preventive care/screening/immunization	No charge	40% coinsurance after deductible	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	Pre-admission certification must be obtained for certain procedures in order to avoid a \$500 penalty.

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# National Franchisee Association – Gold Preferred

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.magellanrx.com">www.magellanrx.com</a> .	Generic drugs	\$20/prescription (retail) \$40/prescription (mail order) after deductible	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred Brand drugs	\$45/prescription (retail) \$90/prescription (mail order) after deductible		
	Non-Preferred Brand drugs	\$75/prescription (retail) \$150/prescription (mail order) after deductible		
	Specialty drugs	20% coinsurance up to a maximum of \$150 per prescription		
<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_____
<b>If you need immediate medical attention</b>	Emergency room services	\$150/visit then 20% coinsurance after in-network deductible		_____none_____
	Emergency medical transportation	20% coinsurance after in-network deductible		_____none_____
	Urgent care	\$40/visit	40% coinsurance after deductible	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$300/confinement then 20% coinsurance after deductible	\$300/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Physician/surgeon fee	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____

**Questions:** Call 1-888-222-9206 or visit us at [www.cbabluevt.com](http://www.cbabluevt.com).

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# National Franchisee Association – Gold Preferred

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$20/visit	40% coinsurance after deductible	—————none—————
	Mental/Behavioral health inpatient services	\$300/confinement then 20% coinsurance after deductible	\$300/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Substance use disorder outpatient services	\$20/visit	40% coinsurance after deductible	—————none—————
	Substance use disorder inpatient services	\$300/confinement then 20% coinsurance after deductible	\$300/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
<b>If you are pregnant</b>	Prenatal and postnatal care	\$20/visit PCP or \$30/visit Specialist applies to first visit to confirm pregnancy, then no charge thereafter for prenatal care; 20% coinsurance for postnatal care	40% coinsurance after deductible	—————none—————
	Delivery and all inpatient services	\$300/confinement then 20% coinsurance after deductible	\$300/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 in order to avoid a \$500 penalty.

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 25 visits per plan year.
	Rehabilitation services	Inpatient: \$300/confinement then 20% coinsurance after deductible  Outpatient: 20% coinsurance after deductible	Inpatient: \$300/confinement then 40% coinsurance after deductible  Outpatient: 40% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
	Skilled nursing care	\$300/confinement then 20% coinsurance after deductible	\$300/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.  Limited to 100 days per plan year.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	—————none—————
	Hospice service	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 6 months per lifetime.
	<b>If your child needs dental or eye care</b>	Eye exam	No charge	40% coinsurance after deductible
Glasses			Not covered	Not covered.
Dental check-up			Not covered	Not covered.

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### Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<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><li>• Most coverage provided outside the United States</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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"><li>• Chiropractic care</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:

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 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](http://www.dol.gov/ebsa), 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).

### 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 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](http://www.dol.gov/ebsa), 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).

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## 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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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## 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 \$4,640
- Patient pays \$2,900

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$1,500
Copays	\$300
Coinsurance	\$950
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,900</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$3,060
- Patient pays \$2,340

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$1,500
Copays	\$100
Coinsurance	\$660
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,340</b>

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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**, **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.

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**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.cbabluevt.com](http://www.cbabluevt.com) or by calling 1-888-222-9206.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$500</b> individual/ <b>\$1,000</b> family for In-Network and <b>\$1,000</b> individual/ <b>\$2,000</b> family for Out-of-Network. Doesn't apply to In-Network preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. <b>\$50</b> individual/ <b>\$100</b> family for In-Network prescription drug coverage. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>\$1,050</b> individual/ <b>\$2,100</b> family for In-Network, <b>\$2,100</b> individual/ <b>\$4,200</b> family for Out-of-Network.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, pre-certification penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.cbabluevt.com">www.cbabluevt.com</a> or call 1-888-222-9206 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20/visit	40% coinsurance after deductible	—————none—————
	Specialist visit	\$30/visit	40% coinsurance after deductible	—————none—————
	Other practitioner office visit	\$30/visit for chiropractic care	40% coinsurance after deductible for chiropractic care	Chiropractic care is limited to a maximum benefit of \$1,000 per plan year.
	Preventive care/screening/immunization	No charge	40% coinsurance after deductible	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	Pre-admission certification must be obtained for certain procedures in order to avoid a \$500 penalty.

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# National Franchisee Association – Platinum Choice

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

Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.magellanrx.com">www.magellanrx.com</a> .	Generic drugs	\$10/prescription (retail) \$20/prescription (mail order) after deductible	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred Brand drugs	\$30/prescription (retail) \$60/prescription (mail order) after deductible		
	Non-Preferred Brand drugs	\$55/prescription (retail) \$110/prescription (mail order) after deductible		
	Specialty drugs	20% coinsurance up to a maximum of \$150 per prescription		
<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_____
<b>If you need immediate medical attention</b>	Emergency room services	\$150/visit then 20% coinsurance after in-network deductible		_____none_____
	Emergency medical transportation	20% coinsurance after in-network deductible		_____none_____
	Urgent care	\$40/visit	40% coinsurance after deductible	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$200/confinement then 20% coinsurance after deductible	\$200/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Physician/surgeon fee	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____

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Coverage Period: 05/01/2015 – 04/30/2016

Coverage for: Individual or Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$20/visit	40% coinsurance after deductible	—————none—————
	Mental/Behavioral health inpatient services	\$200/confinement then 20% coinsurance after deductible	\$200/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
	Substance use disorder outpatient services	\$20/visit	40% coinsurance after deductible	—————none—————
	Substance use disorder inpatient services	\$200/confinement then 20% coinsurance after deductible	\$200/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.
<b>If you are pregnant</b>	Prenatal and postnatal care	\$20/visit PCP or \$30/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	—————none—————
	Delivery and all inpatient services	\$200/confinement then 20% coinsurance after deductible	\$200/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 in order to avoid a \$500 penalty.

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Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 25 visits per plan year.
	Rehabilitation services	Inpatient: \$200/confinement then 20% coinsurance after deductible	Inpatient: \$200/confinement then 20% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
		Outpatient: 20% coinsurance after deductible	Outpatient: 40% coinsurance after deductible	
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to a combined 30 visits per plan year.
	Skilled nursing care	\$200/confinement then 20% coinsurance after deductible	\$200/confinement then 40% coinsurance after deductible	Pre-admission certification must be obtained in order to avoid a \$500 penalty.  Limited to 100 days per plan year.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	—————none—————
	Hospice service	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 6 months per lifetime.
<b>If your child needs dental or eye care</b>	Eye exam	No charge	40% coinsurance after deductible	Eye exams are included in the preventive benefit. See plan document for frequency limitations.
	Glasses	Not covered		Not covered.
	Dental check-up	Not covered		Not covered.

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Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<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><li>• Most coverage provided outside the United States</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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"><li>• Chiropractic care</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:

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 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](http://www.dol.gov/ebsa), 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).

## 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 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](http://www.dol.gov/ebsa), 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).

**Questions:** Call 1-888-222-9206 or visit us at [www.cbabluevt.com](http://www.cbabluevt.com).

If you aren't clear about any of the underlined terms used in this form, 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.

## 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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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## 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 \$6,140
- Patient pays \$1,400

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$500
Copays	\$200
Coinsurance	\$550
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,400</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$4,320
- Patient pays \$1,080

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$500
Copays	\$130
Coinsurance	\$370
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,080</b>

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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**, **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.

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