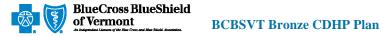


Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.bcbsvt.com/standard-cdhp-cert. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.bcbsvt.com/glossary or call (800) 255-4550 to request a copy.

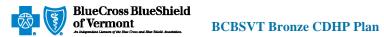
Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$5,500 individual <u>plan</u> / \$11,000 family aggregate. <u>Co-insurance</u> and <u>co-payments</u> do not apply to the <u>deductible</u> . This benefit combines your prescription drug and medical <u>deductibles</u> .	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount each <u>plan</u> year before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. Your <u>plan</u> year: 01/01/2021 through 12/31/2021.
Are there services covered before you meet your <u>deductible</u> ?	Yes, <u>preventive care</u> , wellness drugs	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>co-payment</u> or <u>co-insurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other <u>deductibles</u> for specific services?	No. There are no other specific <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$6,900 individual <u>plan</u> . Family plans have an individual <u>out-of-pocket limit</u> of \$8,550 and \$13,800 aggregate family. <u>Prescription drugs</u> : \$1,400 individual <u>plan</u> / \$2,800 family aggregate. Medical and prescription drug out-of-pocket limits are combined.	The <u>out-of-pocket limit</u> is the most you could pay in a <u>plan</u> year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the out-of-pocket limit ?	Premiums, <u>balance-billing</u> charges, adult vision care, adult dental services and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsvt.com/findadoctor or call (800) 255 -4550 for a list of <u>network</u> providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan</u> 's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

All <u>co-payment</u> and <u>co-insurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You	Will Pay	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Primary care visit to treat an injury or illness	50% <u>co-insurance</u> * for primary care physician and mental health / substance abuse	Not covered	Some services require <u>prior approval</u> . For clarification on mental health services visit www.bcbsvt.com/mental-health-primary-care.
	<u>Specialist</u> visit	50% co-insurance*	Not covered	Some services require prior approval.
If you visit a health care provider's office or clinic	Other practitioner office visit	50% <u>co-insurance</u> * for chiropractic care, nutritional counseling, outpatient physical, speech, and occupational therapy	Not covered	Some services require <u>prior approval</u> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined. Nutritional counseling benefits are covered up to 3 visits. There is no limit on the number of nutritional counseling visits for treatment of diabetes.
	Preventive care/Screening/ Immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. For clarification on <u>preventive services</u> visit www.bcbsvt.com/preventive.
If you have a test	Diagnostic test (x-ray, blood work)	50% <u>co-insurance</u> * for office- based and outpatient hospital	Not covered	Some services require prior approval.
If you have a test	Imaging (CT/PET scans, MRIs)	50% <u>co-insurance</u> *	Not covered	Most services require prior approval.



Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period Begins: 01/01/2021 Coverage For: All Plan Type: EPO

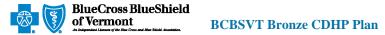
		What You	Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
	Generic drugs	\$12 <u>co-payment</u> * per prescription	Not covered	Covers up to a 30-day supply for most <u>prescription drugs</u> . Some prescriptions require <u>prior approval</u> .	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is	Preferred brand drugs	40% <u>co-insurance</u> *	Not covered	Covers up to a 30-day supply for most <u>prescription drugs</u> . Some prescriptions require <u>prior approval</u> .	
at www.bcbsvt.com/rxcenter. This <u>plan</u> follows the National Performance	Non-preferred brand drugs	60% <u>co-insurance</u> *	Not covered	Covers up to a 30-day supply for most <u>prescription drugs</u> . Some prescriptions require <u>prior approval</u> .	
Formulary (NPF).	Wellness drugs	\$12 <u>co-payment</u> per prescription generic, 40% <u>co-</u> <u>insurance</u> preferred, 60% <u>co-</u> <u>insurance</u> non-preferred	Not covered	Covers up to a 30-day supply for most <u>prescription drugs</u> . Some prescriptions require <u>prior approval</u> .	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	50% <u>co-insurance</u> *	Not covered	Some services require prior approval.	
surgery	Physician/surgeon fees	50% co-insurance*	Not covered	Some services require prior approval.	
If you need immediate medical attention	Emergency room care	50% <u>co-insurance</u> * for facility and <u>physician services</u>	50% <u>co-insurance</u> * for facility and <u>physician</u> <u>services</u>	Must meet emergency criteria.	
	Emergency medical transportation	50% <u>co-insurance</u> *	50% co-insurance*	Must meet emergency criteria.	
	Urgent care	50% co-insurance*	50% co-insurance*	Applies to <u>urgent care</u> facilities.	
If you have a hospital stay	Facility fee (e.g., hospital room)	50% co-insurance*	Not covered	Out-of-state inpatient care requires <u>prior</u> <u>approval</u> .	
	Physician/surgeon fee	50% co-insurance*	Not covered	Some services require prior approval.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% co-insurance*	Not covered	Some services require prior approval.	
	Inpatient services	50% <u>co-insurance</u> *	Not covered	Includes facility and physician fees. Requires prior approval.	



Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period Begins: 01/01/2021 Coverage For: All Plan Type: EPO

		What You	ı Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
If you are pregnant	Office Visits	50% <u>co-insurance</u> *	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). For a list of services visit www.bcbsvt.com/preventive.	
	Childbirth/delivery professional services	50% co-insurance*	Not covered	Out-of-state inpatient care requires <u>prior</u> <u>approval</u> .	
	Childbirth/delivery facility services	50% <u>co-insurance</u> *	Not covered	Out-of-state inpatient care requires <u>prior</u> <u>approval</u> .	
	Home health care	50% <u>co-insurance</u> *	Not covered	Home infusion therapy requires <u>prior approval</u> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.	
If you need help recovering or have other special health needs	Rehabilitation services	50% <u>co-insurance</u> * inpatient; cardiac / pulmonary services 50% <u>co-insurance</u> *	Not covered	Inpatient <u>rehabilitation services</u> require <u>prior</u> <u>approval</u> .	
	Habilitation services	50% <u>co-insurance</u> * for inpatient services	Not covered	Requires <u>prior approval</u> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.	
	Skilled nursing care (facility)	50% co-insurance*	Not covered	Requires <u>prior approval</u> .	
	Durable medical equipment (including supplies)	50% co-insurance*	Not covered	May require <u>prior approval</u> .	
	Hospice	50% co-insurance*	Not covered	None	



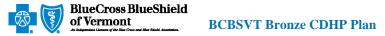
Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period Begins: 01/01/2021 Coverage For: All Plan Type: EPO

		What You	ı Will Pay	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Eye exam	50% <u>co-insurance</u> * per child exam; 100% of charges for adult exam	Not covered	One routine exam per calendar year.
If your child needs dental or eye care	Glasses	50% <u>co-insurance</u> * for child glasses; 100% of charges for adult glasses	Not covered	One pair of exchange-level frames and lenses for prescription glasses or one pair of equivalent contact lenses per calendar year.
	Dental check-up	Child: Class I: No charge*, Class II: 30% <u>co-insurance</u> *, Class III: 50% <u>co-insurance</u> * Adult: 100% of charges	Not covered	Some services require <u>prior approval</u> . <u>Deductible</u> does not apply to Preventive fluoride supplements for children with non- fluoridated drinking water.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)			
Acupuncture	 Cosmetic Surgery (except with prior approval for reconstruction) 	• Dental care (age 21 and older)	
Hearing aids	 Infertility Medications 	Long-term care	
• Routine eye care (age 21 and older)	 Routine foot care (except for treatment of diabetes) 	Weight loss programs	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
Abortion	Bariatric surgery	 Chiropractic Care (requires prior approval after 12 visits) 	
• Non-emergency care when traveling outside the U.S. (www.bcbsvt.com/coveragewhiletraveling)	• Private-duty nursing (covered up to 14 hours per plan year)		



Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>, or the Department of Health and Human Services at (877) 267-2323 x61565 or <u>www.cciio.cms.gov</u>. You may also contact the <u>plan</u> at (800) 247-2583. Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call (800) 318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: (800) 255-4550.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have <u>Minimum Essential Coverage</u> for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

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

BlueCross BlueShield of Vermont biotechical data for the function of the function biotechical data for the function of the function

\$5,500 / \$11,000 Deductible, 50% co-insurance

Coverage Examples

About these Coverage Examples:

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

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Peg is Having a Baby (9 months of in-network pre-natal ca hospital delivery)	are and a	Managing Joe's type 2 Diabe (a year of routine in-network care of controlled condition)		Mia's Simple Fracture (in-network emergency room visit and care)	follow up
 The plan's overall deductible Specialist co-insurance Hospital (facility) co-insurance Other co-insurance Other co-insurance This EXAMPLE event includes services like: Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) 	\$5,500 50% 50% 50%	 The plan's overall deductible <u>Specialist co-insurance</u> Hospital (facility) <u>co-insurance</u> Other <u>co-insurance</u> Other <u>co-insurance</u> This EXAMPLE event includes services like: Primary care physician office visits (including a education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter) 	\$5,500 50% 50% 50% disease	 The plan's overall deductible Specialist co-insurance Hospital (facility) co-insurance Other co-insurance Other co-insurance This EXAMPLE event includes services like: Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy) 	\$5,500 50% 50% 50%
Specialist visit <i>(anesthesia)</i> Total Example Cost	\$12,700	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$5,500	Deductibles	\$5,500	Deductibles	\$1,630
Co-payments	\$0	Co-payments	\$100	Co-payments	\$0
Co-insurance	\$1,400	Co-insurance	\$690	Co-insurance	\$150
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0

The plan would be responsible for the other costs of these EXAMPLE covered services.

The total Joe would pay is

The prescription drug out-of-pocket limit might not be included in the above Coverage Examples.

Custom Summary Name:

The total Peg would pay is

\$6.960

: BCBS-EPO-CDHP-STANDARD-BRONZE-X-BASE-2021 (MD26609)_BCBS-RxHIX-0-1400-x-12-40%-60%-x-P(RX26684)_(13627VT0350002 1024936

\$6,350

The total Mia would pay is

\$1,780

Coverage Period Begins: 01/01/2021 Coverage For: All Plan Type: EPO



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NOTICE: Discrimination is Against the Law

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

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

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

SPANISH

ITALIAN

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

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

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

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ご利用は、(800) 247-2583

までお電話ください。

सेवाहरूका लागि, (800) 247-2583

नि:शल्क भाषा सहायता

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

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

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

TAGALOG

VIETNAMESE

Para sa libreng mga serbisyo

Để biết các dich vu hỗ trơ

ngôn ngữ miễn phí, hãy

goi số (800) 247-2583.

sa (800) 247-2583.

ng tulong pangwika, tumawag

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

Para servicios gratuitos de للحصول على خدمات المساعدة asistencia con el idioma, اللغوية المجانية، اتصل على الرقم .(800) 247-2583

GERMAN

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

llame al (800) 247-2583. FRENCH

Per i servizi gratuiti di

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

PORTUGUESE

JAPANESE

NEPALI

Para serviços gratuitos de assistenza linguistica, chiamare assistência linguística, ligue il numero (800) 247-2583. para o (800) 247-2583.

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

SERBO-CROATIAN (SERBIAN)

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

THAI สำหรับการให้บริการความ ช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

CHINESE

如需免費語言協 助服務,請致電 (800) 247-2583 °

CUSHITE (OROMO)

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