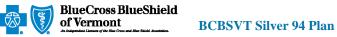
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\$5 PCP / \$15 Specialist co-payment, \$200 / \$400 Deductible
Pharmacy: \$5 co-payment / \$20 co-payment / 30% co-insurance
Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

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-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 <a href="http://www.bcbsvt.com/glossary">http://www.bcbsvt.com/glossary</a> or call (800) 255-4550 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <b><u>deductible</u></b> ?	\$200 individual / \$400 family stacked. <u>Co-insurance</u> and <u>co-payments</u> do not apply to the <u>deductible</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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . Your <u>plan</u> year: 01/01/2022 through 12/31/2022.
Are there services covered before you meet your <u>deductible</u> ?	Yes, <u>preventive care</u> , office visits, <u>urgent care</u> , <u>emergency medical transportation</u> , dental class I and <u>prescription drugs</u>	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> ?	\$900 individual <u>plan</u> . Family plans have an individual <u>out-of-pocket limit</u> of \$900 and \$1,800 family stacked. <u>Prescription drugs</u> : \$200 individual <u>plan</u> / \$400 family. 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> , they have to meet their own out-of- pocket limits until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <b>out-of-pocket limit</b> ?	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 plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). 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 provider 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> .

Coverage Period Begins: 01/01/2022

Coverage For: All Plan Type: EPO



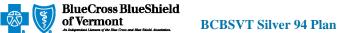
\$5 PCP / \$15 Specialist co-payment, \$200 / \$400 Deductible Pharmacy: \$5 co-payment / \$20 co-payment / 30% co-insurance

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

Coverage For: All Plan Type: EPO

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	\$5 <u>co-payment</u> per visit for <u>primary care physician</u> 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	\$15 <u>co-payment</u> per visit	Not covered	Some services require prior approval.
If you visit a health care provider's office or clinic	Other practitioner office visit	\$7 <u>co-payment</u> per visit for chiropractic care and outpatient physical therapy; \$15 <u>co-payment</u> per visit for nutritional counseling, outpatient 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)	10% <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)	10% <u>co-insurance</u> *	Not covered	Most services require prior approval.



\$5 PCP / \$15 Specialist co-payment, \$200 / \$400 Deductible

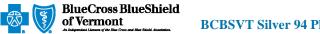
Pharmacy: \$5 co-payment / \$20 co-payment / 30% co-insurance

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

## **Coverage Period Begins: 01/01/2022**

Coverage For: All Plan Type: EPO

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 need drugs to treat	Generic drugs	\$5 <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> .
your illness or condition. More information about prescription drug coverage is	Preferred brand drugs	\$20 <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> .
at www.bcbsvt.com/rxcenter. This <u>plan</u> follows the National Performance	Non-preferred brand drugs	30% co-insurance	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	Wellness <u>prescription drugs</u> process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most <u>prescription drugs</u> . Some prescriptions require prior approval.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	10% <u>co-insurance</u> *	Not covered	Some services require <u>prior approval</u> .
surgery	Physician/surgeon fees	10% co-insurance*	Not covered	Some services require <u>prior approval</u> .
If you need immediate	Emergency room care	\$75 <u>co-payment</u> * per visit for facility services; no charge* for <u>physician services</u>	\$75 <u>co-payment</u> * per visit for facility services; no charge* for <u>physician</u> <u>services</u>	Must meet emergency criteria.
medical attention	Emergency medical transportation	\$50 <u>co-payment</u> per member per day	\$50 <u>co-payment</u> per member per day	Must meet emergency criteria.
	Urgent care	\$25 <u>co-payment</u> per visit	\$25 <u>co-payment</u> per visit	Applies to <u>urgent care</u> facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)		Not covered	Out-of-state inpatient care requires prior approval.
n you have a nospital stay	Physician/surgeon fees	10% co-insurance*	Not covered	Some services require <u>prior approval</u> .
If you need mental health,	Outpatient services	10% co-insurance*	Not covered	Some services require prior approval.
behavioral health, or substance abuse services	Inpatient services	10% <u>co-insurance</u> *	Not covered	Includes facility and physician fees. Requires prior approval.



**BCBSVT Silver 94 Plan** 

\$5 PCP / \$15 Specialist co-payment, \$200 / \$400 Deductible

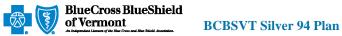
Pharmacy: \$5 co-payment / \$20 co-payment / 30% co-insurance

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

## **Coverage Period Begins: 01/01/2022**

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	\$5 <u>co-payment</u> (One <u>co-payment</u> covers all office visits by one <u>network</u> <u>provider</u> )	Not covered	<u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Depending on the type of services, a <u>co-payment</u> , <u>co-insurance</u> , or <u>deductible</u> 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	10% co-insurance*	Not covered	Out-of-state inpatient care requires <u>prior</u> <u>approval</u> .
	Childbirth/delivery facility services	10% co-insurance*	Not covered	Out-of-state inpatient care requires <u>prior</u> <u>approval</u> .
	Home health care	10% <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	Rehabilitation services	10% <u>co-insurance</u> * inpatient; cardiac / pulmonary services 10% <u>co-insurance</u> *	Not covered	Inpatient <u>rehabilitation services</u> require <u>prior</u> <u>approval</u> .
or have other special health needs	Habilitation services	10% <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)	10% co-insurance*	Not covered	Requires <u>prior approval</u> .
	Durable medical equipment (including supplies)	10% co-insurance*	Not covered	May require <u>prior approval</u> .
	Hospice	10% co-insurance*	Not covered	None



\$5 PCP / \$15 Specialist co-payment, \$200 / \$400 Deductible

Pharmacy: \$5 co-payment / \$20 co-payment / 30% co-insurance

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

## **Coverage Period Begins: 01/01/2022**

#### 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	\$20 <u>co-payment</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	\$20 <u>co-payment</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	<ul> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> </ul>	r • Dental care (age 21 and older)			
Hearing aids	<ul> <li>Infertility Medications</li> </ul>	<ul> <li>Long-term care</li> </ul>			
• Routine eye care (age 21 and older)	• Routine foot care (except for treatment of diabetes)	<ul> <li>Weight loss programs</li> </ul>			
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	<ul> <li>Chiropractic Care (requires prior approval after 12 visits)</li> </ul>			
• Non-emergency care when traveling outside the U.S. (www.bcbsvt.com/coveragewhiletraveling)	<ul> <li>Private-duty nursing (covered up to 14 hours per plan year)</li> </ul>				



\$5 PCP / \$15 Specialist co-payment, \$200 / \$400 Deductible
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Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

#### **Your Rights to Continue Coverage:**

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 on how 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.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

#### Does this plan meet the Minimum Value Standards? Yes.

If your <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 **BCBSVT Silver 94 Plan** 

\$5 PCP / \$15 Specialist co-payment, \$200 / \$400 Deductible Pharmacy: \$5 co-payment / \$20 co-payment / 30% co-insurance

## **Coverage Examples**

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

pay under unterent health plans		e inese coverage examples are based o	in sen-only co	Neldye.	
<b>Peg is Having a Baby</b> (9 months of in-network pre-natal ca hospital delivery)	are and a	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well- controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
<ul> <li>The plan's overall deductible</li> <li>Specialist co-payment</li> <li>Hospital (facility) co-insurance</li> <li>Other co-insurance</li> <li>Other co-insurance</li> <li>This EXAMPLE event includes services like: Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)</li> </ul>	\$200 \$15 10% 10%	<ul> <li>The plan's overall deductible</li> <li>Specialist co-payment</li> <li>Hospital (facility) co-insurance</li> <li>Other co-insurance</li> <li>Other co-insurance</li> <li>This EXAMPLE event includes services like: Primary care physician office visits (including education)</li> <li>Diagnostic tests (blood work)</li> <li>Prescription drugs</li> <li>Durable medical equipment (glucose meter)</li> </ul>	\$200 \$15 10% 10% disease	<ul> <li>The plan's overall deductible</li> <li>Specialist co-payment</li> <li>Hospital (facility) co-insurance</li> <li>Other co-insurance</li> <li>Other co-insurance</li> <li>This EXAMPLE event includes services like: Emergency room care (including medical supplies)</li> <li>Diagnostic test (x-ray)</li> <li>Durable medical equipment (crutches)</li> <li>Rehabilitation services (physical therapy)</li> </ul>	\$200 \$15 10% 10%
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
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	\$200	Deductibles	\$200	Deductibles	\$200
Co-payments	\$10	Co-payments	\$450	Co-payments	\$130
Co-insurance	\$700	Co-insurance	\$70	Co-insurance	\$40
What isn't covered		What isn't covered		What isn't covered	

Limits or exclusions	
The total Peg would pay is	

Cost Sharing			
Deductibles	\$200		
Co-payments	\$450		
Co-insurance	\$70		
What isn't covered			
Limits or exclusions	\$20		
The total Joe would pay is	\$740		

Cost Sharing			
Deductibles	\$200		
Co-payments	\$130		
Co-insurance	\$40		
What isn't covered			
Limits or exclusions \$0			
The total Mia would pay is	\$370		

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

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

\*Note: This plan has other deductibles for specific services included in the coverage example. See "Are there other deductible for specific services?" row above.

\$50 \$960

## **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.

無料の诵訳サービスの

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

मा कल गर्नुहोस्।

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.