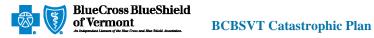


Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

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/catastrophic-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.

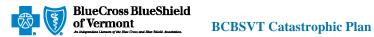
| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| What is the overall<br>deductible?  | \$9,100 individual / \$18,200 family aggregate.<br><u>Co-insurance</u> and <u>co-payments</u> do not apply to the<br><u>deductible</u> . This benefit combines your prescription drug<br>and medical <u>deductibles</u> .  | Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount<br>each <u>plan</u> year before this <u>plan</u> begins to pay. If you have other family members on<br>the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.<br>Your <u>plan</u> year: 01/01/2023 through 12/31/2023.  |
| Are there services covered<br>before you meet your<br><u>deductible</u> ? | health and substance abuse office visits (including  | 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><br><u>limit</u> for this <u>plan</u> ?   | <ul> <li>\$9,100 individual <u>plan</u>. Family plans have an individual <u>out-of-pocket limit</u> of \$9,100 and \$18,200 aggregate family. <u>Prescription drugs</u>: \$1,500 individual <u>plan</u> /</li> <li>\$3,000 family aggregate. Medical and prescription drug out-of-pocket limits are combined.</li> </ul> | The <u>out-of-pocket limit</u> is the most you could pay in a <u>plan</u> year for covered services.<br>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 <b>out-of-pocket limit</b> ?                  | Premiums, <u>balance-billing</u> charges, adult vision care,<br>adult dental services and health care this <u>plan</u> doesn't<br>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<br>a <u>network provider</u> ?               | Yes. See www.bcbsvt.com/findadoctor or call (800) 255<br>-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's 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). For certain <u>emergency services</u> and/or services at an in-network hospital or surgical center (as explained below), the maximum amount you may pay is the <u>plan</u> 's in <u>network</u> cost sharing amount. In these circumstances, the providers cannot balance bill you. 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.

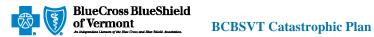
|   |  | What You  | ı Will Pay   |  |  |
|---|--|---|--|--|--|
| Common<br>Medical Event                                   | Services You May Need                            | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions & Other<br>Important Information   |  |
|   | Primary care visit to treat an injury or illness | No charge* for <u>primary care</u><br><u>physician</u> and mental health /<br>substance abuse                           | Not covered  | Some services require <u>prior approval</u> .<br><u>Deductible</u> and <u>co-payments</u> do not apply to<br>some services see www.bcbsvt.com/nonstd-<br>copays for more information. For clarification<br>on mental health services visit<br>www.bcbsvt.com/mental-health-primary-care.   |  |
|   | Specialist visit                                 | No charge*  | Not covered  | Some services require prior approval.  |  |
| If you visit a health care<br>provider's office or clinic | Other practitioner office visit                  | No charge* for chiropractic<br>care, nutritional counseling,<br>outpatient physical, speech<br>and occupational therapy | Not covered  | Some services require <u>prior approval</u> .<br>Outpatient physical, speech and occupational<br>therapy benefits are covered up to 30 visits<br>combined. Nutritional counseling benefits<br>requires <u>prior approval</u> after 3 visits. There is<br>no limit on the number of nutritional<br>counseling visits for treatment of diabetes. |  |
|   | Preventive care/Screening/<br>Immunization       | No charge   | Not covered  | You may have to pay for services that aren't<br>preventive. Ask your <u>provider</u> if the services<br>needed are preventive. Then check what your<br><u>plan</u> will pay for. For clarification on<br><u>preventive services</u> visit<br>www.bcbsvt.com/preventive.  |  |
| If you have a test  | Diagnostic test (x-ray, blood<br>work)           | No charge* for office-based and outpatient hospital   | Not covered  | Some services require <u>prior approval</u> .<br><u>Deductible</u> and <u>co-payments</u> do not apply to<br>some services see www.bcbsvt.com/nonstd-<br>copays for more information.  |  |
|   | Imaging (CT/PET scans, MRIs)                     | No charge*  | 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: 01/01/2023 Coverage For: All Plan Type: EPO

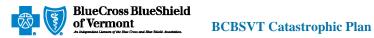
|   |  | What Yo   | u Will Pay   |  |  |
|---|--|---|--|--|--|
| Common<br>Medical Event   | Services You May Need                          | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions & Other<br>Important Information   |  |
| If you need drugs to treat<br>your illness or condition.<br>More information about<br><u>prescription drug coverage</u> is<br>at www.bcbsvt.com/rxcenter.<br>This <u>plan</u> follows the<br>National Performance<br>Formulary (NPF). | Generic drugs                                  | No charge*                                      | Not covered  | Covers up to a 30-day supply for most <u>prescription drugs</u> . Some prescriptions require <u>prior approval</u> .   |  |
|   | Preferred brand drugs                          | No charge*                                      | Not covered  | Covers up to a 30-day supply for most <u>prescription drugs</u> . Some prescriptions require <u>prior approval</u> .   |  |
|   | Non-preferred brand drugs                      | No charge*                                      | Not covered  | Covers up to a 30-day supply for most <u>prescription drugs</u> . Some prescriptions require <u>prior approval</u> .   |  |
|   | Wellness drugs                                 | No charge*                                      | 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<br>surgery   | Facility fee (e.g., ambulatory surgery center) | No charge*                                      | Not covered  | Some services require <u>prior approval</u> . If you<br>see an <u>out-of-network provider</u> at an in-<br><u>network</u> facility, the most the <u>provider</u> may bill<br>you is the in-network <u>cost-sharing</u> amount. |  |
|   | Physician/surgeon fees                         | No charge*                                      | Not covered  | Some services require <u>prior approval</u> . If you<br>see an <u>out-of-network provider</u> at an in-<br><u>network</u> facility, the most the <u>provider</u> may bill<br>you is the in-network <u>cost-sharing</u> amount. |  |



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

## Coverage Period Begins: 01/01/2023 Coverage For: All Plan Type: EPO

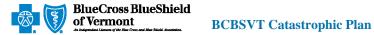
| Common<br>Medical Event                           | Services You May Need               | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions & Other<br>Important Information   |
|---|-------------------------------------|---|--|--|
|   | Emergency room care                 | No charge* for facility and physician services  | No charge* for facility and physician services     | Must meet emergency criteria. If you have an<br>emergency medical condition, and get<br>emergency services from an <u>out-of-network</u><br><u>provider</u> or facility, the maximum you may pay<br>is the standard in-network <u>cost-sharing</u> amount<br>and you cannot be balance billed.   |
| If you need immediate medical attention           | Emergency medical<br>transportation | No charge*                                      | No charge*   | Must meet emergency criteria. If you have an <u>emergency medical condition</u> , and get <u>emergency services</u> from an <u>out-of-network</u> <u>provider</u> or facility, the maximum you may pay is the standard in-network <u>cost-sharing</u> amount and you cannot be balance billed.   |
|   | <u>Urgent care</u>                  | No charge*                                      | No charge*   | Applies to <u>urgent care</u> facilities. If you have an <u>emergency medical condition</u> , and get <u>emergency services</u> from an <u>out-of-network</u> <u>provider</u> or facility, the maximum you may pay is the standard in-network <u>cost-sharing</u> amount and you cannot be balance billed.   |
| If you have a hospital stay                       | Facility fee (e.g., hospital room)  | No charge*                                      | Not covered  | Out-of-state inpatient care requires <u>prior</u><br><u>approval</u> . If you receive care from an <u>out-of-</u><br><u>network provider</u> at an in-network hospital or<br>ambulatory surgical center, the most the<br><u>provider</u> may bill you is the in-network <u>cost</u><br><u>sharing</u> amount and the <u>provider</u> cannot<br>balance bill you. |
|   | Physician/surgeon fees              | No charge*                                      | Not covered  | Some services require <u>prior approval</u> . If you receive care from an <u>out-of-network provider</u> at an in-network hospital or ambulatory surgical center, the most the <u>provider</u> may bill you is the in-network <u>cost sharing</u> amount and the <u>provider</u> cannot balance bill you.  |
| If you need mental health,                        | Outpatient services                 | No charge*                                      | Not covered  | Some services require prior approval.  |
| behavioral health, or<br>substance abuse services | Inpatient services                  | No charge*                                      | 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: 01/01/2023 Coverage For: All Plan Type: EPO

|  |   | What You  | ı Will Pay   |   |  |
|--|---|---|--|---|--|
| Common<br>Medical Event  | Services You May Need                             | In-Network Provider<br>(You will pay the least)                     | Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions & Other<br>Important Information  |  |
| If you are pregnant  | Office Visits                                     | No charge*  | Not covered  | Cost sharing does not apply for preventive<br>services. Depending on the type of services, a<br>deductible may apply. Maternity care may<br>include tests and services described elsewhere<br>in the SBC (i.e. ultrasound.). For a list of<br>services visit www.bcbsvt.com/preventive. |  |
|  | Childbirth/delivery professional services         | No charge*  | Not covered  | Out-of-state inpatient care requires <u>prior</u><br><u>approval</u> .  |  |
|  | Childbirth/delivery facility services             | No charge*  | Not covered  | Out-of-state inpatient care requires <u>prior</u><br><u>approval</u> .  |  |
| If you need help recovering<br>or have other special health<br>needs | Home health care                                  | No charge*  | Not covered  | Home infusion therapy requires <u>prior approval</u> .<br>Outpatient physical, speech and occupational<br>therapy benefits are covered up to 30 visits<br>combined.   |  |
|  | Rehabilitation services                           | No charge* inpatient; cardiac<br>/ pulmonary services no<br>charge* | Not covered  | Inpatient <u>rehabilitation services</u> require <u>prior</u><br><u>approval</u> .  |  |
|  | Habilitation services                             | No charge* for inpatient services                                   | Not covered  | Requires <u>prior approval</u> . Outpatient physical,<br>speech and occupational therapy benefits are<br>covered up to 30 visits combined.  |  |
|  | Skilled nursing care (facility)                   | No charge*  | Not covered  | Requires prior approval.  |  |
|  | Durable medical equipment<br>(including supplies) | No charge*  | Not covered  | May require <u>prior approval</u> .   |  |
|  | Hospice   | No charge*  | Not covered  | None  |  |



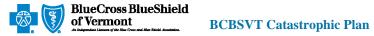
## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

## Coverage Period Begins: 01/01/2023 Coverage For: All Plan Type: EPO

|   |                       | What You  | ı Will Pay   |   |  |
|---|-----------------------|---|--|---|--|
| Common<br>Medical Event                   | Services You May Need | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions & Other<br>Important Information  |  |
| If your child needs dental or<br>eye care | Eye exam              | No charge* per child exam;<br>100% of charges for adult<br>exam   | Not covered  | One routine exam per calendar year.   |  |
|   | Glasses               | No charge* for child glasses;<br>100% of charges for adult<br>glasses                                   | Not covered  | One pair of exchange-level frames and lenses<br>for prescription glasses or one pair of<br>equivalent contact lenses per calendar year.                                       |  |
|   | Dental check-up       | Child: Class I: No charge*,<br>Class II: No charge*, Class<br>III: No charge* Adult: 100%<br>of charges | Not covered  | Some services require <u>prior approval</u> .<br><u>Deductible</u> does not apply to Preventive<br>fluoride supplements for children with non-<br>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> | • Dental care (age 21 and older)  |  |  |  |
| Hearing aids   | <ul> <li>Infertility Medications</li> </ul>  | Long-term care  |  |  |  |
| • Routine eye care (age 21 and older)  | <ul> <li>Routine foot care (except for treatment of diabetes)</li> </ul>             | 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  | <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)   | • 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 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 Catastrophic Plan

\$9,100 / \$18,200 Deductible, 0% 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.

|  |                              | <u> </u>  | ,                            |  |                              |
|--|------------------------------|---|------------------------------|--|------------------------------|
| <b>Peg is Having a Baby</b><br>(9 months of in-network pre-natal ca<br>hospital delivery)  | are and a                    | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-<br>controlled condition)  |                              | Mia's Simple Fracture<br>(in-network emergency room visit and follow up<br>care)   |                              |
| <ul> <li>The plan's overall deductible</li> <li>Specialist co-payment</li> <li>Hospital (facility) co-payment</li> <li>Other co-payment</li> <li>Other co-payment</li> <li>This EXAMPLE event includes services like:<br/>Specialist office visits (prenatal care)<br/>Childbirth/Delivery Professional Services<br/>Childbirth/Delivery Facility Services</li> <li>Diagnostic tests (ultrasounds and blood work)<br/>Specialist visit (anesthesia)</li> </ul> | \$9,100<br>\$0<br>\$0<br>\$0 | <ul> <li>The plan's overall deductible</li> <li>Specialist co-payment</li> <li>Hospital (facility) co-payment</li> <li>Other co-payment</li> <li>This EXAMPLE event includes services like:<br/>Primary care physician office visits (including<br/>education)</li> <li>Diagnostic tests (blood work)</li> <li>Prescription drugs</li> <li>Durable medical equipment (glucose meter)</li> </ul> | \$9,100<br>\$0<br>\$0<br>\$0 | <ul> <li>The plan's overall deductible</li> <li>Specialist co-payment</li> <li>Hospital (facility) co-payment</li> <li>Other co-payment</li> <li>Other co-payment</li> <li>This EXAMPLE event includes services like:<br/>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> | \$9,100<br>\$0<br>\$0<br>\$0 |
| 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  | \$9,100                      | Deductibles   | \$5,420                      | Deductibles  | \$2,640                      |
| Co-payments  | \$0                          | Co-payments   | \$0                          | Co-payments  | \$0                          |
| Co-insurance   | \$0                          | Co-insurance  | \$0                          | Co-insurance   | \$0                          |
| What isn't covered   |                              | What isn't covered  |                              | What isn't covered   |                              |
| Limits or exclusions   | \$50                         | Limits or exclusions  | \$20                         | Limits or exclusions   | \$0                          |
| The total Peg would pay is   | \$9,150                      | The total Joe would pay is  | \$5,440                      | The total Mia would pay is   | \$2,640                      |

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.

## **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)

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