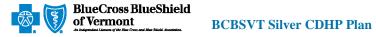


Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

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.

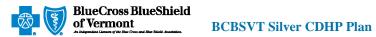
Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$2,100 individual <u>plan</u> / \$4,200 family aggregate. <u>Co-insurance</u> and <u>co-payments</u> do not apply to the <u>deductible</u> . This benefit combines your prescription drug and medical <u>deductibles</u> .	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: 01/01/2023 through 12/31/2023.
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> ?	\$7,050 individual <u>plan</u> . Family plans have an individual <u>out-of-pocket limit</u> of \$9,100 and \$14,100 family aggregate. <u>Prescription drugs</u> : \$1,500 individual <u>plan</u> / \$3,000 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'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's in network cost-sharing</u> 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.

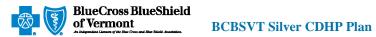
	What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Primary care visit to treat an injury or illness	10% <u>co-insurance</u> * for <u>primary 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	30% co-insurance*	Not covered	Some services require prior approval.
If you visit a health care provider's office or clinic	Other practitioner office visit	30% <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 requires <u>prior approval</u> after 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.
	Diagnostic test (x-ray, blood work)	30% <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)	30% <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: 01/01/2023 Coverage For: All Plan Type: EPO

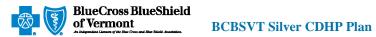
		What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is at www.bcbsvt.com/rxcenter. This <u>plan</u> follows the National Performance Formulary (NPF).	Generic drugs	\$10 <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> .	
	Preferred brand drugs	\$40 <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> .	
	Non-preferred brand drugs	50% <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> .	
	Wellness drugs	\$10 <u>co-payment</u> per prescription generic, \$40 <u>co-</u> <u>payment</u> per prescription preferred, 50% <u>co-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 surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>co-insurance</u> *	Not covered	Some services require <u>prior approval</u> . If you see an <u>out-of-network provider</u> at an in- network facility, the most the <u>provider</u> may bill you is the in-network <u>cost-sharing</u> amount.	
	Physician/surgeon fees	30% <u>co-insurance</u> *	Not covered	Some services require <u>prior approval</u> . If you see an <u>out-of-network provider</u> at an in- network facility, the most the <u>provider</u> may bill 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

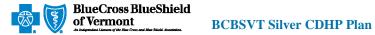
		What You	Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
If you need immediate medical attention	Emergency room care	30% <u>co-insurance</u> * for facility and <u>physician services</u>	30% <u>co-insurance</u> * for facility and <u>physician</u> <u>services</u>	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.	
	Emergency medical transportation	30% <u>co-insurance</u> *	30% <u>co-insurance</u> *	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>	30% <u>co-insurance</u> *	30% <u>co-insurance</u> *	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)	30% <u>co-insurance</u> *	Not covered	Out-of-state inpatient care requires <u>prior</u> <u>approval</u> . If you receive care from an <u>out-of-</u> <u>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-</u> <u>sharing</u> amount and the <u>provider</u> cannot balance bill you.	
	Physician/surgeon fees	30% <u>co-insurance</u> *	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	30% co-insurance*	Not covered	Some services require prior approval.	
behavioral health, or substance abuse services	Inpatient services	30% <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: 01/01/2023 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	
If you are pregnant	Office Visits	10% <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	30% co-insurance*	Not covered	Out-of-state inpatient care requires <u>prior</u> <u>approval</u> .	
	Childbirth/delivery facility services	30% <u>co-insurance</u> *	Not covered	Out-of-state inpatient care requires <u>prior</u> <u>approval</u> .	
If you need help recovering or have other special health needs	Home health care	30% <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.	
	Rehabilitation services	30% <u>co-insurance</u> * inpatient; cardiac / pulmonary services 30% <u>co-insurance</u> *	Not covered	Inpatient <u>rehabilitation services</u> require <u>prior</u> <u>approval</u> .	
	Habilitation services	30% <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)	30% co-insurance*	Not covered	Requires <u>prior approval</u> .	
	Durable medical equipment (including supplies)	30% <u>co-insurance</u> *	Not covered	May require <u>prior approval</u> .	
	Hospice	30% <u>co-insurance</u> *	Not covered	None	



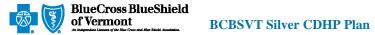
Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

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

		What You	ı Will Pay	
Common 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 your child needs dental or eye care	Eye exam	\$20 <u>co-payment</u> * per child exam; 100% of charges for adult exam	Not covered	One routine exam per calendar year.
	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	 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 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 A host of the Out of the State durates BCBSVT Silver CDHP Plan

\$2,100 / \$4,200 Deductible, 30% co-insurance

Coverage Examples

About these Coverage Examples:

The total Peg would pay is

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)	ire 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)	
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist co-insurance</u> Hospital (facility) <u>co-insurance</u> Other <u>co-insurance</u> 	\$2,100 30% 30% 30%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist co-insurance</u> Hospital (facility) <u>co-insurance</u> Other <u>co-insurance</u> 	\$2,100 30% 30% 30%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist co-insurance</u> Hospital (facility) <u>co-insurance</u> Other <u>co-insurance</u> 	\$2,100 30% 30% 30%
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)		This EXAMPLE event includes services like: Primary care physician office visits <i>(including education)</i> Diagnostic tests <i>(blood work)</i> Prescription drugs Durable medical equipment <i>(glucose meter)</i>	disease	This EXAMPLE event includes services like: Emergency room care <i>(including medical supplies)</i> Diagnostic test <i>(x-ray)</i> Durable medical equipment <i>(crutches)</i> Rehabilitation services <i>(physical therapy)</i>	
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	\$2,100	Deductibles	\$2,100	Deductibles	\$2,100
Co-payments	\$10	Co-payments	\$440	Co-payments	\$0
Co-insurance	\$2,990	Co-insurance	\$260	Co-insurance	\$160
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 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.

\$2,820

The total Mia would pay is

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

\$5,150

\$2,260

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.