

\$2,000/\$4,000 deductible, 30% coinsurance

Wellness Drugs: \$10 copayment/\$40 copayment/50% coinsurance

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

**Coverage Period Begins:** 01-01-2026

**Coverage For:** All **Plan Type:** EPO



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, <https://www.bluecrossvt.org/cdhp-cert-2026>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call (800) 255-4550 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                                           | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$2,000 individual <a href="#">plan</a> / \$4,000 family aggregate. <a href="#">Coinsurance</a> and <a href="#">copayments</a> do not apply to the <a href="#">deductible</a> . This benefit combines your prescription drug and medical deductibles.                                                                             | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount each <a href="#">plan</a> year before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay. Your plan year: 01-01-2026 through 12-31-2026.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes, preventive services and wellness drugs                                                                                                                                                                                                                                                                                       | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                                                                                                                                                                                                            |
| Are there other <a href="#">deductibles</a> for specific services?              | No. There are no other specific <a href="#">deductibles</a> .                                                                                                                                                                                                                                                                     | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$6,175 individual plan. Family plans have an individual <a href="#">out-of-pocket limit</a> of \$10,600 and \$12,350 family aggregate. <a href="#">Prescription drugs</a> : \$1,700 individual <a href="#">plan</a> / \$3,400 family aggregate. Medical and <a href="#">prescription drug out-of-pocket limits</a> are combined. | The <a href="#">out-of-pocket limit</a> is the most you could pay in a <a href="#">plan</a> year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Premiums, <a href="#">balance-billing</a> charges, adult vision care, adult dental services and health care this <a href="#">plan</a> doesn't cover.                                                                                                                                                                              | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.bluecrossvt.org/find-doctor">www.bluecrossvt.org/find-doctor</a> or call (800) 255-4550 for a list of <a href="#">network</a> providers.                                                                                                                                                             | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). For certain <a href="#">emergency services</a> and/or services at an in-network hospital or surgical center (as explained below), the maximum amount you may pay is the <a href="#">plan's</a> in <a href="#">network cost-sharing</a> amount. In these circumstances, |

| Important Questions                                                          | Answers | Why This Matters:                                                                                        |
|------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------|
|                                                                              |         | the providers cannot balance bill you. Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No.     | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .               |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                                                                                          | Services You May Need                                                     | What You Will Pay                                                                                                                     |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                               |                                                                           | Network Provider<br>(You will pay the least)                                                                                          | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                           |
| <b>If you visit a health care <a href="#">provider</a>'s office or clinic</b>                                                                 | Primary care visit to treat an injury or illness                          | 10% <a href="#">coinsurance</a> * for <a href="#">primary care physician</a> and mental health / substance use                        | Not covered                                        | Some services require <a href="#">prior approval</a> . For clarification on mental health services visit <a href="http://www.bluecrossvt.org/members/coverage">www.bluecrossvt.org/members/coverage</a> .                                                                                                                                                 |
|                                                                                                                                               | <a href="#">Specialist</a> visit                                          | 30% <a href="#">coinsurance</a> *                                                                                                     | Not covered                                        | Some services require <a href="#">prior approval</a> .                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                               | Other practitioner office visit                                           | 30% <a href="#">coinsurance</a> * for chiropractic care, nutritional counseling, outpatient physical, speech and occupational therapy | Not covered                                        | Some services require <a href="#">prior approval</a> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.                                                                                                                                                                                                |
|                                                                                                                                               | <a href="#">Preventive care</a> / <a href="#">Screening</a> /Immunization | No charge                                                                                                                             | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. For clarification on <a href="#">preventive services</a> visit <a href="http://www.bluecrossvt.org/members/coverage">www.bluecrossvt.org/members/coverage</a> . |
| <b>If you have a test</b>                                                                                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)                       | 30% <a href="#">coinsurance</a> * for office-based and outpatient hospital                                                            | Not covered                                        | Some services require <a href="#">prior approval</a> .                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                               | Imaging (CT/PET scans, MRIs)                                              | 30% <a href="#">coinsurance</a> *                                                                                                     | Not covered                                        | Most services require <a href="#">prior approval</a> .                                                                                                                                                                                                                                                                                                    |
| <b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at | Generic drugs                                                             | \$10 <a href="#">copayment</a> * per prescription                                                                                     | Not covered                                        | Covers up to a 30-day supply for most prescription drugs. Some prescriptions require <a href="#">prior approval</a> .                                                                                                                                                                                                                                     |
|                                                                                                                                               | Preferred brand drugs                                                     | \$40 <a href="#">copayment</a> * per prescription                                                                                     | Not covered                                        | Covers up to a 30-day supply for most prescription drugs. Some prescriptions require <a href="#">prior approval</a> .                                                                                                                                                                                                                                     |

\*Deductible applies to these services.

| Common Medical Event                                                                                                                                                        | Services You May Need                            | What You Will Pay                                                                                                                                                  |                                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                             |                                                  | Network Provider<br>(You will pay the least)                                                                                                                       | Out-of-Network Provider<br>(You will pay the most)                    |                                                                                                                                                                                                                                                                                            |
| <a href="http://www.bluecrossvt.org/pharmacies-medications">www.bluecrossvt.org/pharmacies-medications</a> .<br>This plan follows the National Performance Formulary (NPF). | Non-preferred brand drugs                        | 50% <a href="#">coinsurance</a> *                                                                                                                                  | Not covered                                                           | Covers up to a 30-day supply for most prescription drugs. Some prescriptions require <a href="#">prior approval</a> .                                                                                                                                                                      |
|                                                                                                                                                                             | Wellness drugs                                   | \$10 <a href="#">copayment</a> per prescription generic, \$40 <a href="#">copayment</a> per prescription preferred, 50% <a href="#">coinsurance</a> non-preferred. | Not covered                                                           | Covers up to a 30-day supply for most prescription drugs. Some prescriptions require <a href="#">prior approval</a> .                                                                                                                                                                      |
| If you have outpatient surgery                                                                                                                                              | Facility fee (e.g., ambulatory surgery center)   | 30% <a href="#">coinsurance</a> *                                                                                                                                  | Not covered                                                           | Some services require <a href="#">prior approval</a> . If you see an <a href="#">out-of-network provider</a> at an in-network facility, the most the <a href="#">provider</a> may bill you is the in-network <a href="#">cost-sharing</a> amount.                                          |
|                                                                                                                                                                             | Physician/surgeon fees                           | 30% <a href="#">coinsurance</a> *                                                                                                                                  | Not covered                                                           | Some services require <a href="#">prior approval</a> . If you see an <a href="#">out-of-network provider</a> at an in-network facility, the most the <a href="#">provider</a> may bill you is the in-network <a href="#">cost-sharing</a> amount.                                          |
| If you need immediate medical attention                                                                                                                                     | <a href="#">Emergency room care</a>              | 30% <a href="#">coinsurance</a> * for facility and physician services                                                                                              | 30% <a href="#">coinsurance</a> * for facility and physician services | Must meet emergency criteria. If you have an emergency medical condition, and get emergency services from an <a href="#">out-of-network provider</a> or facility, the maximum you may pay is the standard in-network <a href="#">cost-sharing</a> amount and you cannot be balance billed. |
|                                                                                                                                                                             | <a href="#">Emergency medical transportation</a> | 30% <a href="#">coinsurance</a> *                                                                                                                                  | 30% <a href="#">coinsurance</a> *                                     | Must meet emergency criteria. If you have an emergency medical condition, and get emergency services from an <a href="#">out-of-network provider</a> or facility, the maximum you may pay is the standard in-network <a href="#">cost-sharing</a> amount and you cannot be balance billed. |

\*Deductible applies to these services.

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                           | <a href="#">Urgent care</a>               | 30% <a href="#">coinsurance</a> *            | 30% <a href="#">coinsurance</a> *                  | Applies to urgent care facilities. If you have an emergency medical condition, and get emergency services from an <a href="#">out-of-network provider</a> or facility, the maximum you may pay is the standard in-network <a href="#">cost-sharing</a> amount and you cannot be balance billed.                                                                                                                                                              |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 30% <a href="#">coinsurance</a> *            | Not covered                                        | Out-of-state inpatient care requires <a href="#">prior approval</a> . If you receive care from an <a href="#">out-of-network provider</a> at an in-network hospital or ambulatory surgical center, the most the <a href="#">provider</a> may bill you is the in-network <a href="#">cost-sharing</a> amount and the <a href="#">provider</a> cannot balance bill you.                                                                                        |
|                                                                           | Physician/surgeon fees                    | 30% <a href="#">coinsurance</a> *            | Not covered                                        | Some services require <a href="#">prior approval</a> . If you receive care from an <a href="#">out-of-network provider</a> at an in-network hospital or ambulatory surgical center, the most the <a href="#">provider</a> may bill you is the in-network <a href="#">cost-sharing</a> amount and the <a href="#">provider</a> cannot balance bill you.                                                                                                       |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 30% <a href="#">coinsurance</a> *            | Not covered                                        | Some services require <a href="#">prior approval</a> .                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                           | Inpatient services                        | 30% <a href="#">coinsurance</a> *            | Not covered                                        | Includes facility and physician fees. Requires <a href="#">prior approval</a> .                                                                                                                                                                                                                                                                                                                                                                              |
| If you are pregnant                                                       | Office visits                             | 10% <a href="#">coinsurance</a> *            | Not covered                                        | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). For a list of services visit <a href="http://www.bluecrossvt.org/members/coverage">www.bluecrossvt.org/members/coverage</a> . |
|                                                                           | Childbirth/delivery professional services | 30% <a href="#">coinsurance</a> *            | Not covered                                        | Out-of-state inpatient care requires <a href="#">prior approval</a> .                                                                                                                                                                                                                                                                                                                                                                                        |

\*Deductible applies to these services.

| Common Medical Event                                                  | Services You May Need                                          | What You Will Pay                                                                                                                                     |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                               |
|-----------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                                                | Network Provider<br>(You will pay the least)                                                                                                          | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                      |
|                                                                       | Childbirth/delivery facility services                          | 30% <a href="#">coinsurance</a> *                                                                                                                     | Not covered                                        | Out-of-state inpatient care requires <a href="#">prior approval</a> .                                                                                                                |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>                               | 30% <a href="#">coinsurance</a> *                                                                                                                     | Not covered                                        | Home infusion therapy requires <a href="#">prior approval</a> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.                  |
|                                                                       | <a href="#">Rehabilitation services</a>                        | 30% <a href="#">coinsurance</a> * inpatient;<br>30% <a href="#">coinsurance</a> * cardiac / pulmonary services                                        | Not covered                                        | Inpatient rehabilitation services require <a href="#">prior approval</a> .                                                                                                           |
|                                                                       | <a href="#">Habilitation services</a>                          | 30% <a href="#">coinsurance</a> * for inpatient services                                                                                              | Not covered                                        | Requires <a href="#">prior approval</a> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.                                        |
|                                                                       | <a href="#">Skilled nursing care</a> (facility)                | 30% <a href="#">coinsurance</a> *                                                                                                                     | Not covered                                        | Requires <a href="#">prior approval</a> .                                                                                                                                            |
|                                                                       | <a href="#">Durable medical equipment</a> (including supplies) | 30% <a href="#">coinsurance</a> *                                                                                                                     | Not covered                                        | May require <a href="#">prior approval</a> .                                                                                                                                         |
|                                                                       | <a href="#">Hospice services</a>                               | 30% <a href="#">coinsurance</a> *                                                                                                                     | Not covered                                        | None                                                                                                                                                                                 |
| <b>If your child needs dental or eye care</b>                         | <a href="#">Eye exam</a>                                       | \$20 <a href="#">copayment</a> * per child exam; 100% of charges for adult exam                                                                       | Not covered                                        | One routine exam per calendar year.                                                                                                                                                  |
|                                                                       | Glasses                                                        | \$20 <a href="#">copayment</a> * 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*,<br>Class II: 30% <a href="#">coinsurance</a> *,<br>Class III: 50% <a href="#">coinsurance</a> *<br>Adult: 100% of charges | Not covered                                        | Some services require <a href="#">prior approval</a> . <a href="#">Deductible</a> does not apply to Preventive fluoride supplements for children with non-fluoridated drinking water |

\*Deductible applies to these services.

### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery (except with prior approval for reconstruction)
- Dental care (age 21 and older)
- Infertility Medications
- Long-term care
- Routine eye care (age 21 and older)
- Weight loss programs

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Bariatric surgery
- Chiropractic care (requires prior approval after 12 visits)
- Hearing aids (covered up to one per ear every three years)
- Non-emergency care when traveling outside the U.S. ([www.bluecrossvt.org/members/coverage](http://www.bluecrossvt.org/members/coverage))
- Private-duty nursing (covered up to 14 hours per plan year)
- Routine foot care

### 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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). You may also contact the plan at (800) 247-2583. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call (800) 318-2596.

### Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. 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 plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

## About these 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, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000 |
| ■ <u>Specialist coinsurance</u>               | 30%     |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,000        |
| <u>Copayments</u>                 | \$10           |
| <u>Coinsurance</u>                | \$2,500        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,570</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000 |
| ■ <u>Specialist coinsurance</u>               | 30%     |
| ■ Hospital (facility)                         | \$0     |
| ■ Other <u>coinsurance</u>                    | 30%     |

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,000        |
| <u>Copayments</u>                 | \$40           |
| <u>Coinsurance</u>                | \$70           |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,130</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000 |
| ■ <u>Specialist coinsurance</u>               | 30%     |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,000        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$80           |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,080</b> |

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

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# **DISCLAIMERS**

## **General Exclusions**

While your health plan covers a broad array of necessary services and supplies, it doesn't cover every possible medical expense. If you would like to review the list of general exclusions before enrolling, visit [bluecrossvt.org/contracts](https://bluecrossvt.org/contracts), click on the plan in which you are enrolling and read the chapter entitled "General Exclusions." Once you enroll, you will receive an Outline of Coverage and a link to your Certificate of Coverage. Please read both carefully as they govern your specific benefits.

## **How We Protect Your Privacy**

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law.

You may find information about our privacy practices at [bluecrossvt.org/privacypolicies](https://bluecrossvt.org/privacypolicies).

## **NOTICE: Discrimination is Against the Law**

Blue Cross® and Blue Shield® of Vermont (Blue Cross VT) 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, ethnicity, sexual orientation, or HIV-status.

Blue Cross VT 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).

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

If you need these services, contact [civilrightscoordinator@bcbsvt.com](mailto:civilrightscoordinator@bcbsvt.com).

If you believe that Blue Cross VT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status,

you can file a grievance with: Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583 (TTY/TDD: 711), fax (802) 229-0511, or email [civilrightscordinator@bcbsvt.com](mailto:civilrightscordinator@bcbsvt.com). You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically or 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  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>

**For free language-assistance service, call (800) 247-2583 (TTY/TDD: 711).**

|                 |                                                                                                                                                                                             |
|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ARABIC          | للحصول على خدمات المساعدة اللغوية المجانية ، اتصل<br>(800) 247 2583 (TTY/TDD: 711). lilhusul ealaa khadmat<br>almusaeadat allughawiat almajaaniat, atasal<br>(800) 247-2583 (TTY/TDD: 711). |
| CHINESE         | 如需免費語言支援服務，請致電 (800) 247-2583<br>TTY/TDD: 711).                                                                                                                                             |
| CUSHITE (OROMO) | Tajaajila gargaarsa afaanii bilisaa argachuuf,<br>(800) 247-2583 (TTY/TDD: 711) bilbili.                                                                                                    |
| FRENCH          | Pour des services d'assistance linguistique gratuits,<br>appelez le (800) 247-2583 (TTY/TDD: 711).                                                                                          |
| GERMAN          | Für kostenlose Sprachunterstützungsdienste rufen Sie<br>(800) 247-2583 (TTY/TDD: 711) an.                                                                                                   |
| ITALIAN         | Per i servizi di assistenza linguistica gratuiti, chiamare il<br>numero (800) 247-2583 (TTY/TDD: 711).                                                                                      |
| JAPANESE        | 無料の言語支援サービスについては、<br>(800) 247-2583 (TTY/TDD: 711).                                                                                                                                         |
| NEPALI          | निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस् ,<br>(800) 247-2583 (TTY/TDD: 711). Niḥśulka bhāṣā-<br>sahāyatā sēvāharūkō lāgi, kala garnuhōs<br>(800) 247-2583 (TTY/TDD: 711).          |

|                             |                                                                                                                                                             |
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| PORTUGUESE                  | Para serviços gratuitos de assistência linguística, ligue para (800) 247-2583 (TTY/TDD: 711).                                                               |
| RUSSIAN                     | Чтобы получить бесплатную языковую помощь, позвоните по телефону (800) 247-2583 (TTY/TDD: 711).                                                             |
| SERBO-CROATIAN<br>(SERBIAN) | За бесплатне услуге језичке помоћи позовите (800) 247-2583 (TTY/TDD: 711). Za besplatne usluge jezičke pomoći pozovite (800) 247-2583 (TTY/TDD: 711).       |
| SPANISH                     | Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).                                                                 |
| TAGALOG                     | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583 (TTY/TDD: 711). |
| THAI                        | สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร. (800) 247-2583 (TTY/TDD: 711). Šạ̉hrạb brikār cḥwyh̄elụx đản phās'ā frī thor (800) 247-2583 (TTY/TDD: 711).          |
| UKRAINIAN                   | Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583 (TTY/TDD: 711). Shchob otrymaty                                                          |

## VIETNAMESE

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Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi  
(800) 247-2583 (TTY/TDD: 711).