


\$5 PCP / \$15 Specialist co-payment, \$250 / \$500 Deductible  
Pharmacy: \$5 co-payment / \$20 co-payment / 30% co-insurance

**Coverage Period Begins: 01/01/2023**

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

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

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

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$250 individual / \$500 family stacked.  <a href="#">Co-insurance</a> and <a href="#">co-payments</a> do not apply to the <a href="#">deductible</a> .	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 <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . Your <a href="#">plan</a> year: 01/01/2023 through 12/31/2023.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, <a href="#">preventive care</a> , office visits, <a href="#">urgent care</a> , <a href="#">emergency medical transportation</a> , dental class I, <a href="#">prescription drugs</a>	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="#">co-payment</a> or <a href="#">co-insurance</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> ?	\$1,000 individual <a href="#">plan</a> . Family plans have an individual <a href="#">out-of-pocket limit</a> of \$1,000 and \$2,000 family stacked. <a href="#">Prescription drugs</a> : \$200 individual <a href="#">plan</a> / \$400 family. Medical and prescription drug out-of-pocket limits 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> , they have to meet their own out-of-pocket limits until the overall family <a href="#">out-of-pocket limit</a> has been 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.bcbsvt.com/findadoctor">www.bcbsvt.com/findadoctor</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, 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> .

\*Deductible applies to these services.

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All [co-payment](#) and [co-insurance](#) 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider</a> 's office or clinic	Primary care visit to treat an injury or illness	\$5 <a href="#">co-payment</a> per visit for <a href="#">primary care physician</a> and mental health / substance abuse	Not covered	Some services require <a href="#">prior approval</a> . <a href="#">Deductible</a> and <a href="#">co-payments</a> do not apply to some services see [www.bcbsvt.com/non-stdcopays] for more information. For clarification on mental health services visit www.bcbsvt.com/mental-health-primary-care.
	<a href="#">Specialist</a> visit	\$15 <a href="#">co-payment</a> per visit	Not covered	Some services require <a href="#">prior approval</a> .
	Other practitioner office visit	\$6 <a href="#">co-payment</a> per visit for chiropractic care and outpatient physical therapy; \$15 <a href="#">co-payment</a> per visit for nutritional counseling, outpatient 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. Nutritional counseling benefits requires <a href="#">prior approval</a> after 3 visits. There is no limit on the number of nutritional counseling visits for treatment of diabetes.
	<a href="#">Preventive care/Screening/Immunization</a>	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 www.bcbsvt.com/preventive.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">co-insurance</a> * for office-based and outpatient hospital	Not covered	Some services require <a href="#">prior approval</a> .
	Imaging (CT/PET scans, MRIs)	10% <a href="#">co-insurance</a> *	Not covered	Most services require <a href="#">prior approval</a> .

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition. More information about <a href="http://www.bcbsvt.com/rxcenter">prescription drug coverage</a> is at <a href="http://www.bcbsvt.com/rxcenter">www.bcbsvt.com/rxcenter</a> . This <a href="#">plan</a> follows the National Performance Formulary (NPF).	Generic drugs	\$5 <a href="#">co-payment</a> per prescription	Not covered	Covers up to a 30-day supply for most <a href="#">prescription drugs</a> . Some prescriptions require <a href="#">prior approval</a> .
	Preferred brand drugs	\$20 <a href="#">co-payment</a> per prescription	Not covered	Covers up to a 30-day supply for most <a href="#">prescription drugs</a> . Some prescriptions require <a href="#">prior approval</a> .
	Non-preferred brand drugs	30% <a href="#">co-insurance</a>	Not covered	Covers up to a 30-day supply for most <a href="#">prescription drugs</a> . Some prescriptions require <a href="#">prior approval</a> .
	Wellness drugs	Wellness <a href="#">prescription drugs</a> process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most <a href="#">prescription drugs</a> . Some prescriptions require <a href="#">prior approval</a> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">co-insurance</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	10% <a href="#">co-insurance</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.

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		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$75 <a href="#">co-payment</a> * per visit for facility services; no charge* for <a href="#">physician services</a>	\$75 <a href="#">co-payment</a> * per visit for facility services; no charge* for <a href="#">physician services</a>	Must meet emergency criteria. If you have an <a href="#">emergency medical condition</a> , and get <a href="#">emergency services</a> 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>	\$50 <a href="#">co-payment</a> per member per day	\$50 <a href="#">co-payment</a> per member per day	Must meet emergency criteria. If you have an <a href="#">emergency medical condition</a> , and get <a href="#">emergency services</a> 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="#">Urgent care</a>	\$25 <a href="#">co-payment</a> per visit	\$25 <a href="#">co-payment</a> per visit	Applies to <a href="#">urgent care</a> facilities. If you have an <a href="#">emergency medical condition</a> , and get <a href="#">emergency services</a> 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)	10% <a href="#">co-insurance</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	10% <a href="#">co-insurance</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	10% <a href="#">co-insurance</a> *	Not covered	Some services require <a href="#">prior approval</a> .
	Inpatient services	10% <a href="#">co-insurance</a> *	Not covered	Includes facility and physician fees. Requires <a href="#">prior approval</a> .

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		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office Visits	\$5 <u>co-payment</u> (One <u>co-payment</u> covers all office visits by one <u>network provider</u> )	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>co-payment</u> , <u>co-insurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). For a list of services visit <a href="http://www.bcbsvt.com/preventive">www.bcbsvt.com/preventive</a> .
	Childbirth/delivery professional services	10% <u>co-insurance</u> *	Not covered	Out-of-state inpatient care requires <u>prior approval</u> .
	Childbirth/delivery facility services	10% <u>co-insurance</u> *	Not covered	Out-of-state inpatient care requires <u>prior approval</u> .
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>co-insurance</u> *	Not covered	Home infusion therapy requires <u>prior approval</u> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.
	<u>Rehabilitation services</u>	10% <u>co-insurance</u> * inpatient; cardiac / pulmonary services 10% <u>co-insurance</u> *	Not covered	Inpatient <u>rehabilitation services</u> require <u>prior approval</u> .
	<u>Habilitation services</u>	10% <u>co-insurance</u> * for inpatient services	Not covered	Requires <u>prior approval</u> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.
	<u>Skilled nursing care</u> (facility)	10% <u>co-insurance</u> *	Not covered	Requires <u>prior approval</u> .
	<u>Durable medical equipment</u> (including supplies)	10% <u>co-insurance</u> *	Not covered	May require <u>prior approval</u> .
	<u>Hospice</u>	10% <u>co-insurance</u> *	Not covered	None

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		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Eye exam	\$20 <a href="#">co-payment</a> per child exam; 100% of charges for adult exam	Not covered	One routine exam per calendar year.
	Glasses	\$20 <a href="#">co-payment</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, Class II: 30% <a href="#">co-insurance</a> *, Class III: 50% <a href="#">co-insurance</a> * 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.

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Hearing aids</li> <li>Routine eye care (age 21 and older)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (except with prior approval for reconstruction)</li> <li>Infertility Medications</li> <li>Routine foot care (except for treatment of diabetes)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (age 21 and older)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Abortion</li> <li>Non-emergency care when traveling outside the U.S. (<a href="http://www.bcbsvt.com/coveragewhiletraveling">www.bcbsvt.com/coveragewhiletraveling</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Private-duty nursing (covered up to 14 hours per plan year)</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care (requires prior approval after 12 visits)</li> </ul>

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### 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 page.*—————

**Coverage Examples**

**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](#), [co-payments](#) and [co-insurance](#)) 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 pre-natal care and a hospital delivery)		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 <a href="#">plan's overall deductible</a>	\$250	■ The <a href="#">plan's overall deductible</a>	\$250	■ The <a href="#">plan's overall deductible</a>	\$250
■ <a href="#">Specialist co-payment</a>	\$15	■ <a href="#">Specialist co-payment</a>	\$15	■ <a href="#">Specialist co-payment</a>	\$15
■ Hospital (facility) <a href="#">co-insurance</a>	10%	■ Hospital (facility) <a href="#">co-insurance</a>	10%	■ Hospital (facility) <a href="#">co-insurance</a>	10%
■ Other <a href="#">co-insurance</a>	10%	■ Other <a href="#">co-insurance</a>	10%	■ Other <a href="#">co-insurance</a>	10%
This EXAMPLE event includes services like: Specialist office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests ( <i>ultrasounds and blood work</i> ) Specialist visit ( <i>anesthesia</i> )		This EXAMPLE event includes services like: Primary care physician office visits ( <i>including disease education</i> ) Diagnostic tests ( <i>blood work</i> ) Prescription drugs Durable medical equipment ( <i>glucose meter</i> )		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> )	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Mia Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$250	Deductibles	\$250	Deductibles	\$250
Co-payments	\$10	Co-payments	\$450	Co-payments	\$120
Co-insurance	\$750	Co-insurance	\$70	Co-insurance	\$40
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$50	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,060</b>	<b>The total Joe would pay is</b>	<b>\$790</b>	<b>The total Mia would pay is</b>	<b>\$410</b>

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.

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  
civilrightscordinator@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.

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](http://www.hhs.gov/ocr/office/file/index.html).



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

ARABIC

للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583

SPANISH

Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

FRENCH

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

ITALIAN

Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

GERMAN

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

JAPANESE

無料の通訳サービスのご利用は、(800) 247-2583 までお電話ください。

NEPALI

निःशुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN

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

SERBO-CROATIAN (SERBIAN)

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

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

TAGALOG

Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

VIETNAMESE

Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (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.