$300/$600 deductible, 20% coinsurance
Pharmacy: $5 copayment/$20 copayment/$45 copayment
Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period Begins: 01-01-2027
Coverage For: VSTRS **Plan Type**: Indemnity

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.vehi.org/vstrs-health-plan-information. 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 or call (800) 255-4550 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 individual / $600 family. Coinsurance and copayments do not apply to the deductible.	Generally, you must pay all of the costs from providers up to the deductible amount each plan year before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. We apply any portion of your deductible that you pay for services occurring after September 30 each plan year towards your next year's deductible as well. Your plan year: 01-01-2027 through 12-31-2027.
Are there services covered before you meet your deductible?	Yes, prescription drugs	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$600 individual / $1,200 family. Prescription drugs: $600 individual / $1,200 family.	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments on certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bluecrossvt.org/find-doctor or call (800) 255-4550 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). For certain emergency services and/or services at an in-network hospital or surgical center (as explained below), the maximum amount you may pay is the plan's in network cost- sharing amount. In these circumstances, the providers cannot balance bill you. Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

*Deductible applies to these services.

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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance* for primary care physician and mental health / substance use	20% coinsurance* for primary care physician and mental health / substance use	Some services require prior approval. For clarification on mental health services visit www.bluecrossvt.org/members/coverage.
	Specialist visit	20% coinsurance*	20% coinsurance*	Some services require prior approval.
	Other practitioner office visit	20% coinsurance* for chiropractic care, nutritional counseling, outpatient physical, speech and occupational therapy	20% coinsurance* for outpatient physical, speech and occupational therapy; chiropractic care and nutritional counseling not covered	Some services require prior approval. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.
	Preventive care/Screening/ Immunization	20% coinsurance*	20% coinsurance*	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. For clarification on preventive services visit www.bluecrossvt.org/members/coverage.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance* for office-based and outpatient hospital	20% coinsurance* for office-based and outpatient hospital	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	20% coinsurance*	20% coinsurance*	Most services require prior approval.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bluecrossvt.org/pharmacies-medications. This plan follows the National Performance	Generic drugs	$5 copayment / $15 copayment	Not covered	Up to a 30-day supply / 90-day supply for most prescription drugs. Some prescriptions require prior approval. All generic and brand diabetic prescription drugs and diabetic supplies when obtained through your prescription drug benefit are covered at 100%.
	Preferred brand drugs	$20 copayment / $60 copayment	Not covered	Up to a 30-day supply / 90-day supply for most prescription drugs. Some prescriptions require prior approval.

*Deductible applies to these services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
Formulary (NPF).	Non-preferred brand drugs	$45 copayment / $135 copayment	Not covered	Up to a 30-day supply / 90-day supply for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Up to a 30-day supply / 90-day supply for most prescription drugs. Some prescriptions require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance*	20% coinsurance*	Some services require prior approval. If you see an out-of-network provider at an in-network facility, the most the provider may bill you is the in-network cost-sharing amount.
	Physician/surgeon fees	20% coinsurance*	20% coinsurance*	Some services require prior approval. If you see an out-of-network provider at an in-network facility, the most the provider may bill you is the in-network cost-sharing amount.
If you need immediate medical attention	Emergency room care	20% coinsurance* for facility and physician services	20% coinsurance* for facility and physician services	Must meet emergency criteria. If you have an emergency medical condition, and get emergency services from an out-of-network provider or facility, the maximum you may pay is the standard in-network cost-sharing amount and you cannot be balance billed.
	Emergency medical transportation	20% coinsurance*	20% coinsurance*	Must meet emergency criteria. If you have an emergency medical condition, and get emergency services from an out-of-network provider or facility, the maximum you may pay is the standard in-network cost-sharing amount and you cannot be balance billed.
	Urgent care	20% coinsurance*	20% coinsurance*	Applies to urgent care facilities. If you have an emergency medical condition, and get emergency services from an out-of-network provider or facility, the maximum you may pay is the standard in-network cost-sharing 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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	20% coinsurance*	Out-of-state inpatient care requires prior approval. If you receive care from an out-of-network provider at an in-network hospital or ambulatory surgical center, the most the provider may bill you is the in-network cost-sharing amount and the provider cannot balance bill you.
	Physician/surgeon fees	20% coinsurance*	20% coinsurance*	Some services require prior approval. If you receive care from an out-of-network provider at an in-network hospital or ambulatory surgical center, the most the provider may bill you is the in-network cost-sharing amount and the provider cannot balance bill you.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance*	20% coinsurance*	Some services require prior approval.
	Inpatient services	20% coinsurance*	20% coinsurance*	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Office visits	20% coinsurance*	20% coinsurance*	Depending on the type of services, a copayment, coinsurance, 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.bluecrossvt.org/members/coverage.
	Childbirth/delivery professional services	20% coinsurance*	20% coinsurance*	Out-of-state inpatient care requires prior approval.
	Childbirth/delivery facility services	20% coinsurance*	20% coinsurance*	Out-of-state inpatient care requires prior approval.
If you need help recovering or have other special health	Home health care	20% coinsurance*	20% coinsurance*	Home infusion therapy requires prior approval. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.

*Deductible applies to these services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
needs	Rehabilitation services	20% coinsurance* inpatient; 20% coinsurance* cardiac / pulmonary services	20% coinsurance* inpatient; cardiac / pulmonary services not covered	Inpatient rehabilitation services require prior approval.
	Habilitation services	20% coinsurance* for inpatient services	Not covered	Requires prior approval. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.
	Skilled nursing care (facility)	20% coinsurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	20% coinsurance*	20% coinsurance*	May require prior approval.
	Hospice services	20% coinsurance*	20% coinsurance*	None
If your child needs dental or eye care	Eye exam	Not covered	Not covered	None
	Glasses	Not covered	Not covered	None
	Dental check-up	Not covered	Not covered	None

*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 (child and adult)
- Infertility Medications
- Long-term care
- Routine eye care
- Sexual dysfunction drugs
- 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)
- 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, or the Department of Health and Human Services at (877) 267-2323 x61565 or 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 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.

*Deductible applies to these services.

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 plan's overall deductible	$300
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$300
■ Specialist coinsurance	20%
■ Hospital (facility)	$0
■ Other coinsurance	20%

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$70
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$590**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	$300
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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

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**, 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**.

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 who speak or sign languages other than English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, contact the Civil Rights Coordinator at **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 **civilrightscoordinator@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 العربية	للحصول على خدمة المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583 (TTY/TDD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).
BOSNIAN BOSANSKI	Za besplatnu uslugu jezičke pomoći nazovite (800) 247-2583 (TTY/TDD: 711).
BURMESE မြန်မာဘာသာ	အခမဲ့ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုအတွက် (800) 247-2583 (TTY/TDD: 711) သို့ ဖုန်းခေါ်ပါ။
DARI دری	د وړیا ژبنۍ مرستې خدماتو لپاره، له (800) 247-2583 (TTY/TDD: 711) شمیرې سره اړیکه ونیسئ.
FRENCH FRANÇAIS	Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/ TDD: 711).
KIRUNDI IKIRUNDI	Niba ukeneye ubwunganizi mu ndimi ku buntu, hamagara kuri (800) 247-2583 (TTY/TDD: 711).
NEPALI नेपाली	निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस् , (800) 247-2583 (TTY/TDD: 711). Niḥśulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583 (TTY/TDD: 711).
PASHTO پښتو	برای خدمات رایگان کمک زبانی، با شماره (800) 247-2583 (TTY/TDD:711) تماس بگیرید
SIMPLIFIED CHINESE 简体中文	如需免费语言协助服务，请拨打 (800) 247-2583 (TTY/TDD: 711)。
SOMALI SOOMAALI	Si aad u hesho adeeg caawimo luuqadeed ah oo bilaash ah, wac (800) 247-2583 (TTY/TDD: 711).
SPANISH ESPAÑOL	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).
SWAHILI KISWAHILI	Kwa huduma ya usaidizi wa lugha bila malipo, piga simu kwa (800) 247-2583 (TTY/TDD: 711).
THAI ไทย	สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร, (800) 247-2583 (TTY/TDD: 711). S̄ảh̄rạb brikār ch̀wyh̄elụ̄x d̂ān ṗhās̄'ā frī thor (800) 247-2583 (TTY/TDD: 711).
UKRAINIAN УКРАЇНСЬКА МОВА	Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583 (TTY/TDD: 711). Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583 (TTY/TDD: 711)
VIETNAMESE TIẾNG VIỆT	Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).