BlueCross BlueShield of Vermont

TotalChoice Plan: State of Vermont

$300/$600 deductible, 20% co-insurance
Pharmacy: $50 deductible, 10% co-insurance/20% co-insurance/40% co-insurance

Coverage Period Begins: 01/01/2021

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

Coverage For: State of Vermont **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, http://humanresources.vermont.gov/salary/benefits/open_enrollment or by calling (888) 778-5570. 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 **deductible**?	$300 individual / $600 family. Co-insurance and co-payments 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. Your plan year: 01/01/2021 through 12/31/2021. 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.
Are there services covered before you meet your **deductible**?	Yes, preventive services and prescription drugs	This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment or co-insurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other **deductibles** for specific services?	Yes. $50 individual / $150 family prescription drug deductible.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the **out-of-pocket limit** for this plan?	$750 individual / $2,250 family. Prescription drugs: $750 individual / $2,425 family (Generic, Formulary Brand, Specialty drugs); $1,350 individual / $2,700 family (Non-Formulary Brand drugs)	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**?	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.bcbsvt.com/findadoctor 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). 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.

SNO/BPN: 1025383/

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
		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% co-insurance* for primary care physician; no charge per visit for mental health / substance abuse	20% co-insurance* for primary care physician and mental health / substance abuse	Some services require prior approval. For clarification on mental health services visit www.bcbsvt.com/mental-health-primary-care.
	Specialist visit	20% co-insurance*	20% co-insurance*	Some services require prior approval.
	Other practitioner office visit	20% co-insurance* for chiropractic care, nutritional counseling, outpatient physical, speech, and occupational therapy	20% co-insurance* for chiropractic care, nutritional counseling, outpatient physical, speech, and occupational therapy	Some services require prior approval. Outpatient physical, speech, occupational, massage therapy and chiropractic care covered up to 60 visits combined.
	Preventive care/Screening/ Immunization	No charge	No charge	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.bcbsvt.com/preventive.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance* for office-based and outpatient hospital	20% co-insurance* for office-based and outpatient hospital	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	20% co-insurance*	20% co-insurance*	Most services 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)	
If you need drugs to treat your illness or condition.	Generic drugs	$50 deductible, then 10% co-insurance	Not covered	Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	$50 deductible, then 20% co-insurance	Not covered	Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	$50 deductible, then 40% co-insurance	Not covered	Up to a 30-day supply retail / 90-day supply home delivery 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 retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance*	20% co-insurance*	Some services require prior approval.
	Physician/surgeon fees	20% co-insurance*	20% co-insurance*	Some services require prior approval.
If you need immediate medical attention	Emergency room care	20% co-insurance* for facility and physician services	20% co-insurance* for facility and physician services	Must meet emergency criteria.
	Emergency medical transportation	20% co-insurance*	20% co-insurance*	Must meet emergency criteria.
	Urgent care	20% co-insurance*	20% co-insurance*	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance*	10% co-insurance*	Out-of-state inpatient care requires prior approval.
	Physician/surgeon fee	20% co-insurance*	20% co-insurance*	Some services require prior approval.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% co-insurance*	Some services require prior approval.
	Inpatient services	No charge	10% co-insurance*	Includes facility and physician fees. Requires 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)	
If you are pregnant	Office Visits	No charge	20% co-insurance*	Cost sharing does not apply for preventive services. Depending on the type of services, a co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). For a list of services visit www.bcbsvt.com/preventive.
	Childbirth/delivery professional services	10% co-insurance*	10% co-insurance*	Out-of-state inpatient care requires prior approval.
	Childbirth/delivery facility services	10% co-insurance*	10% co-insurance*	Out-of-state inpatient care requires prior approval.
If you need help recovering or have other special health needs	Home health care	20% co-insurance*	20% co-insurance*	Home infusion therapy requires prior approval.
	Rehabilitation services	20% co-insurance* inpatient; cardiac / pulmonary services 20% co-insurance*	20% co-insurance* inpatient services; cardiac / pulmonary services not covered	Inpatient rehabilitation services require prior approval. Cardiac rehabilitation exercise sessions covered up to three per week for up to 12 weeks.
	Habilitation services	20% co-insurance* for inpatient services	20% co-insurance* inpatient services	Requires prior approval.
	Skilled nursing care (facility)	20% co-insurance*	Not covered	Requires prior approval. Covered up to 60 days.
	Durable medical equipment (including supplies)	20% co-insurance*	20% co-insurance*	May require prior approval.
	Hospice	20% co-insurance*	20% co-insurance*	None
If your child needs dental or eye care	Eye exam	Exam and lenses covered up to $100 per adult; no limit per child	Exam and lenses covered up to $100 per adult; no limit per child	One routine exam every 24 months.
	Glasses	Exam and lenses covered up to $100 per adult; no limit per child	Exam and lenses covered up to $100 per adult; no limit per child	One pair of lenses every 24 months.
	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.)

- Cosmetic Surgery (except with prior approval for reconstruction)
- Dental care (child and adult)
- Hearing aids
- Infertility Medications
- Long-term care
- Private-duty nursing
- Routine foot care (except for treatment of diabetes)
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic Care
- Non-emergency care when traveling outside the U.S. (www.bcbsvt.com/coveragewhiletraveling)
- Routine eye care (one routine eye exam per child and adult member every 24 months)

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 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.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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.

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)

The plan's overall deductible	$300
Specialist co-insurance	20%
Hospital (facility) co-insurance	10%
Other co-insurance	10%

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
Co-payments	$0
Co-insurance	$450
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$810**

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 co-insurance	20%
Hospital (facility) co-insurance	10%
Other co-insurance	10%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$350
Co-payments	$0
Co-insurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$810**

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

The plan's overall deductible	$300
Specialist co-insurance	20%
Hospital (facility) co-insurance	10%
Other co-insurance	10%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Co-payments	$0
Co-insurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$630**

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.

Custom Summary Name: BCBS-Comp-300-750-20%-STK-x-x-x-x-x-x-ACA-LARG (MD39216)_BCBS-Rx-50-x-x-10%-20%-40%-2-x-P(RX43685)_Coverage-012021-12312021 (C39162)_Q4 - ACA(RD13554) wQ4ACA CY 1025383

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
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our civil rights coordinator is available to help you.

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**.

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

ARABIC

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

GERMAN

Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (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.

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 prevođenja, 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.