[redacted] Vermont Health Partnership (POS) Open Access Plan

$10 PCP/$20 Specialist co-payment, $250 co-payment Inpatient/$100 Outpatient
Pharmacy $100 deductible, $5 co-payment/$20 co-payment/$40 co-payment

Coverage Period Begins: 01/01/20

Summary of Benefits and Coverage: K D W W K L V 3 O D Q & R Y H U V : K D W < R X 3 D \ I R U & R Y H U H G Coverage for: University of Vermont Plan Type: POS

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 cos 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/vhp_cert. For general definitions of co such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossa 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?	$0 individual / $0 family preferred provider $500 individual / $1,000 family non-preferred provider Co-insurance and co-payments do not apply to the deductible. Preferred services do not apply to the no preferred deductible.	See the Common Medical Events chart below for your costs for services this covers. If you have other family members on this 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: 01/01/2024 through 12/31/2024.
Are there services covere before you meet your deductible?	Yes, non-preferred preventive mammography scree 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 deductil See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $100 individual / $300 family durable medical equipment and supplies deductible. $100 individual / $300 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?	$2,500 individual / $5,000 family preferred provider $2,500 individual / $5,000 family non-preferred provider. The out-of-pocket for preferred and non-preferred providers is separate. Prescription drugs $1,300 individual / $2,600 family.	The out-of-pocket limit is the most you could pay in a plan year for covered service 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 th out-of-pocket limit?	Premiums, balance-billing charges, and health care th 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 us a network provider?	Yes. See www.bluecrossvt.org/find-doctor or call (8 255-4550 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 (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. with your provider before you get services.

*Deductible applies to these services.

SNO/BPN: 1027048/

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Vermont Health Partnership (POS) Open Access Plan

$10 PCP/$20 Specialist co-payment, $250 co-payment Inpatient/$100

Coverage Period Begins: 01/01/20

Coverage For: University of Vermont Plan Type: POS

What You Will Pay		
Common Medical Event	Services You May Need	Preferred Provider (You will pay the least)

Common Medical Event	Services You May Need	What You Will Pay: Preferred Provider (You will pay the least)	What You Will Pay: Non-Preferred Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need drugs to treat your illness or condition. More information about prescription drug coverage is at www.bluecrossvt.org/pharmacies-medications. This plan follows the National Performance Formulary (NPF).	Generic drugs	$100 deductible, then $5 co-payment / $1 co-payment		

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Coverage Period Begins: 01/01/20

Summary of Benefits and Coverage:

Coverage For: University of Vermont Plan Type: POS

Common Medical Event	Services You May Need	What You Will Pay: Preferred Provider (You will pay the least)	What You Will Pay: Non-Preferred Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you are pregnant	Office Visits	$10 co-payment (one co-payment covers all maternity office visits by one network provider)	30% co-insurance	Cost sharing does not apply for preventive services. Depending on the type of services, co-payment 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	No charge	30% co-insurance	Out-of-state inpatient care requires prior approval
	Childbirth/delivery facility services	$250 co-payment per admission (limited to three co-payments per family)	30% co-insurance	Out-of-state inpatient care requires prior approval
If you need help recovering or have other special health needs	Home health care		30% co-insurance	Hominfuissio othapyre requires prio (approv

Common Medical Event

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 Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services at (877) 267-232 x61565 or www.cciio.cms.gov. You may also contact the plan at (800) 247-2583 ConseTjexaoyeesvHeahow c isvn

The plan's overall deductible	
Specialist co-payment	$20
Hospital (facility) co-payment