

**STATE OF VERMONT EMPLOYEE MEDICAL PLAN OPTIONS FOR  
ACTIVE AND RETIRED MEMBERS**

Benefit/Feature	SelectCare POS Plan		TotalChoice Plan
	In-Network	Out-of-Network	
Annual DEDUCTIBLE	none	\$500 per person; \$1,000 per family	\$300 per person; \$600 per family
MAXIMUM annual COPAYS (after deductible is met)	\$2,000 per person; \$6,000 per family	\$2,000 per person; \$6,000 per family	\$750 per person; \$2,250 per family
Maximum Lifetime Benefit Per Member	none	none	none
<b>PERCENTAGE THAT THE PLAN PAYS</b>			
Inpatient Hospital	100% after \$250 co-pay	70%	90%
Outpatient Hospital	100%	70%	80%
Emergency Room	100% after \$75 co-pay (waived if admitted)	70%	80%
Physician Charges			
Office Visit	100% after \$25 copay		80%
Specialist Visit	100% after \$30 copay	70%	90% inpatient; 80% outpatient
MRI	100% after \$30 copay		
In-Hospital Visit	100%		90%
Surgery	100%		
Diagnostic X-ray and Labs	100%	70%	80%
Home Healthcare	100%	70%	80%
<b>COMMON BENEFITS IN ALL PLAN OPTIONS</b>			
Preventive Exams & Tests- Program Benefits	Covered at 100%.		
Wellness Program Benefits	Available to all active employees and retirees in any of the health plan options, at no charge to the employee or retiree		
<b>COMMON BENEFITS IN ALL PLAN OPTIONS EXCEPT THE SAFETYNET PLAN</b>			
Mental Health & Substance Abuse Program Benefits	In-Network: Paid at 100%. Out-of-Network: Deductibles & copay required.		
Prescription Drugs	This prescription drug card plan combines both local retail and mail order drugs. Annual deductible of \$50 per person/\$150 family. Individual pays 10% copay/generic drugs, 20% copay/preferred brand drugs, and 40% copay/non-preferred brand drugs. For both mail order and retail, the maximum annual out-of-pocket, including deductible, is \$800 per covered member for generic drugs and preferred brands, and \$1,350 for non-preferred brand drugs. Total annual out of pocket will not exceed \$1,350/ person, \$2,700/family.		
• Retail			
• Mail			
Routine Vision Care	The plan pays \$100 every two years, with no deductible, coinsurance, or copay. Benefits available for every plan member, <b>including dependents.</b> Covers routine exams and/or lens changes if the prescription changed. Doesn't include replacement lens if lost/damaged.		