

SelectCare POS: State of Vermont

Outline of Coverage

Thank you for choosing Blue Cross and Blue Shield of Vermont for your health coverage. For full details, please read your plan documents. *Blue Cross and Blue Shield of Vermont provides administrative services only and does not assume any financial risk for claims.*

Your overall deductible is: Not applicable.

Your out-of-network deductible is: \$500 individual/ \$1,000 family per plan year. Once you have met your deductible, then you pay 30% coinsurance of the allowed amount, up to your out-of-pocket limit, which is listed below. We apply any portion of your deductible that you pay for services, occurring after September 30 each plan year, toward your next year's deductible as well.

Your prescription drug deductible is: Please refer to your separate pharmacy benefits manager for details on your pharmacy coverage.

Your other deductibles are: Not applicable. Your newborn will be subject to their own cost-sharing for covered services beginning on their date of birth, whether or not you add your newborn to coverage permanently.

Your overall out-of-pocket limit is: \$1,500 individual / \$3,000 family per plan year. Your deductible is included in your out-of-pocket limit.

Your out-of-network out-of-pocket limit is: \$1,500 individual/\$3,000 family per plan year. The out-of-pocket for network and out-of-network providers is combined.

Your out-of-pocket limit for prescription drugs is: Please refer to your separate pharmacy benefits manager for details on your pharmacy coverage.

Do you need a primary care provider? Yes

Do you need a referral to see a specialist? No, but some services require prior approval.

Your contract documents: For a list of your contract documents (Summary Plan Description and riders, if applicable), log in to the Member Resource Center at www.bluecrossvt.org/member-logins or contact customer service at the number listed on the back of your ID card.

Provider Network Information

If you see a network provider for a covered service, you will pay the lowest deductibles, coinsurance, or copayments for select services as outlined in this document. For emergency care, you may use network or out-of-network providers and obtain benefits. However, in cases of emergency or services provided at a network facility, out-of-network providers are prohibited from billing you for amounts beyond the cost-sharing amounts without your permission. If this occurs, please contact us at the number on the back of your ID card so that we can work directly with the Provider to resolve the request. If you use an out-of-network provider, for non-emergency care, and you waived your right to be protected from additional bills, you may be billed the difference between the allowed amount and billed charges which does not accumulate toward your plan year out-of-pocket limit.

For a list of providers in the Vermont network, visit www.bluecrossvt.org/find-doctor and choose "Providers and Hospitals in Vermont Service Area." For a list of national, BlueCard providers, visit www.bluecrossvt.org/find-doctor and choose "National and International Providers and Hospitals." Then, choose the National Doctor and Hospital Finder to access the national directory. Your national BlueCard network of providers is BlueCard PPO/EPO. Please call our customer service team at the number listed on the back of your ID card if you need help selecting a provider. Please refer to your Summary Plan Description, Chapter One, "General Guidelines" on how to access care and choose a network provider.

Service or Supply	Your cost when you use network providers	Restrictions, limitations or other important information *
<p>Preventive Care Well-child care and immunizations Annual OB-GYN exam Preventive care includes routine immunizations, pap tests, preventive laboratory, screening mammograms, colorectal screening and X-rays.</p>	<p>Office visits: No charge</p>	<p>For screening mammograms, you may use network or out-of-network providers and obtain network benefits. Preventive care benefits must meet the plan's definition of screening/preventive. For clarification on preventive services visit www.bluecrossvt.org/preventive.</p>
<p>Office Visits Office examinations, diagnosis and treatment of an injury or illness, and allergy shots Specialty provider's office Care by specialists (e.g. cardiologist, oncologist) Certain short-term therapies (e.g. physical, speech, occupational) Surgery, lab, X-rays, allergy tests, other diagnostic services</p>	<p>Primary care provider: \$25 copayment per visit Specialist: \$30 copayment per visit MH/SUD primary: No charge MH/SUD specialist: No charge Physical, speech, occupational therapy: \$25 copayment per visit Surgery: No charge Diagnostic services: No charge Injections other than immunizations and allergy shots: No charge Other treatments: No charge</p>	<p>See your Summary Plan Description for more details. Outpatient physical, occupational, speech therapy and chiropractic benefits are covered up to 60 visits combined, per plan year. You have a separate but equal combined limit for rehabilitative therapy services. Therapy services provided as treatment for autism spectrum disorder are separate and require prior approval after 60 combined visits. Some surgeries and diagnostic services require prior approval.</p>
<p>Acupuncture</p>	<p>\$25 copayment per visit</p>	<p>This plan provides benefits for acupuncture services. Services with an out-of-network provider are covered at your out-of-network provider benefit level.</p>
<p>Ambulance Services Ambulance service to the nearest Facility in an emergency Non-emergency transfer between facilities Your condition must meet the criteria for an emergency medical condition as listed in your Summary Plan Description.</p>	<p>No charge</p>	<p>All non-emergency ambulance transport requires prior approval. For ambulance services, you may use network and out-of-network providers and obtain network benefits.</p>
<p>Chiropractic Care Services to treat a neuromusculoskeletal condition</p>	<p>\$25 copayment per visit</p>	<p>Outpatient physical, occupational, speech therapy and chiropractic benefits are covered up to 60 visits combined, per plan year.</p>
<p>Dental, Adult</p>	<p>You may have limited dental benefits.</p>	<p>Some dental services, such as medical dental, may be eligible for benefits. See your Summary Plan Description for more details.</p>

Service or Supply	Your cost when you use network providers	Restrictions, limitations or other important information *
Dental, Pediatric	You may have limited dental benefits.	Some dental services, such as medical dental, may be eligible for benefits. See your Summary Plan Description for more details.
Emergency Care Hospital emergency room Emergency provider Mental health (MH) and substance use disorder (SUD) treatment	Facility: \$75 copayment per visit Provider: No charge MH/SUD facility: \$75 copayment per visit MH/SUD provider: No charge	Your condition must meet the criteria for an emergency medical condition. For emergency care, you may use network or out-of-network providers and obtain network benefits. See your Summary Plan Description for more details.
Home Care Skilled nursing visits, short-term therapy, private duty nursing Infusion therapy Hospice	Home health: No charge Hospice: No charge Physical, speech, occupational therapy: No charge	Private duty nursing services are not covered. Outpatient physical, occupational, speech therapy and chiropractic benefits are covered up to 60 visits combined, per plan year. You have a separate but equal combined limit for rehabilitative therapy services. Therapy services provided as treatment for autism spectrum disorder are separate and require prior approval after 60 combined visits
Care in a Hospital Inpatient Care in a Hospital Appropriate room and board accommodations All covered providers' services, including surgery Mental health (MH) and substance use disorder (SUD) treatment Outpatient Care in a Hospital Outpatient surgery Labs, X-rays, EKG and other diagnostic services Physical, speech, occupational therapy Other outpatient Services Advanced imaging (e.g. MRI, CT scan, PET scan, Echo) Mental health (MH) and substance use disorder (SUD) treatment	Facility: \$250 copayment per admission Provider: No charge MH/SUD inpatient: No charge Physical, speech, occupational therapy: \$25 copayment per visit Outpatient provider: No charge. Outpatient surgery facility: No charge Diagnostic services: No charge Advanced imaging: \$30 copayment per visit for MRI/MRA; No charge all other MH/SUD outpatient primary: No charge MH/SUD outpatient specialist: No charge MH/SUD intensive outpatient: No charge	For inpatient care call (800) 922-8778 for prior approval review. You must get prior approval for out-of-state inpatient care. Some surgeries and diagnostic services require prior approval. Outpatient physical, occupational, speech therapy and chiropractic benefits are covered up to 60 visits combined, per plan year. You have a separate but equal combined limit for rehabilitative therapy services. Therapy services provided as treatment for autism spectrum disorder are separate and require prior approval after 60 combined visits. Some outpatient services require prior approval.
Medical Equipment and Supplies Supplies and equipment that are primarily and customarily used only for a medical purpose.	No charge	Some medical equipment and supplies may require prior approval.
Nutritional Counseling	\$30 copayment per visit	See your Summary Plan Description for more details.

Service or Supply	Your cost when you use network providers	Restrictions, limitations or other important information *
OB-GYN Office Visits Gynecological care	\$30 copayment per visit	
Care During Pregnancy Maternity care for mother and child	Inpatient delivery: \$250 copayment per admission Office visit: No charge	Your plan covers preventive prenatal and postnatal care with no cost sharing when received in network. Members enrolled in our Better Beginnings program receive extra benefits.
Rehabilitation and Skilled Nursing Facility Care Inpatient treatment Outpatient cardiac or pulmonary rehabilitation	Inpatient: No charge Cardiac: \$20 copayment per visit Pulmonary: \$20 copayment per visit	You must get prior approval for inpatient rehabilitation, see your Summary Plan Description for full details.
Telemedicine	Acute care: \$25 copayment per visit MH/SUD: No charge Nutritional counseling: \$30 copayment per visit Lactation consultation: \$30 copayment per visit	For telemedicine consultations with a provider, visit www.bluecrossvt.org/find-doctor/telemedicine-care . For telemedicine consultations with a network provider, see service or supply in this document for payment terms and limitations.
Transplant Care Benefits for transplant related office visits, diagnostic services, surgeries and inpatient care	No charge with Blue Distinction Plus provider. See "Service or Supply" above for payment terms with network providers.	Prior approval is required for all transplants except for kidney and cornea. Please see your Summary Plan Description for full details.
Urgent Care Applies to urgent care facilities Includes provider and facility services	\$50 copayment per visit	For urgent care facilities, you may use network and out-of-network providers and obtain network benefits. See your Summary Plan Description for more details.
Vision Care Routine exam to determine visual problems and prescribe any necessary lenses Coverage for prescription or fitting of eyeglasses or contact lenses	Pediatric exam: No charge Pediatric materials: No charge Adult exam: No charge Adult materials: No charge	For optometry services to treat a disease condition, please see your office visit benefit outlined above. One routine exam, including refraction, per member every 24 months. One pair of lenses, per member every 24 months for a new or changed prescriptions. This benefit does not cover frames. Please refer to your Summary Plan Description for additional information. There is a \$100 benefit maximum for routine exams and lenses, per member every 24 months. This limit does not apply to pediatric care for members up to age 21.

How Your Pharmacy Coverage Works

Blue Cross and Blue Shield of Vermont does not administer your pharmacy benefits. Please refer to your separate pharmacy benefits manager for details on your pharmacy coverage, including any applicable deductibles, copayments, coinsurance, or out-of-pocket limits.

Pharmacy-Retail and home delivery copayment

Generic Drugs	Please refer to your separate pharmacy benefits manager for details on your pharmacy coverage.	
Preferred Brand Drugs	Please refer to your separate pharmacy benefits manager for details on your pharmacy coverage.	
Non-Preferred Brand Drugs	Please refer to your separate pharmacy benefits manager for details on your pharmacy coverage.	
Wellness Drugs		
	Please refer to your separate pharmacy benefits manager for details on your pharmacy coverage.	

*Under certain circumstances, when ordered by a primary care physician, the prior authorizations indicated in this chart would not be applicable.

This plan provides benefits for select infertility services. Please refer to your Summary Plan Description for additional information. There is a benefit maximum of \$50,000 for covered infertility treatment services. This benefit maximum does not apply to diagnostic services performed to determine if and why a person is infertile. Out-of-Network Durable Medical Equipment (DME) is limited to a \$700 annual maximum, per member, per plan year. Out-of-Network Prosthetics are limited to a \$700 annual maximum, per member, per plan year. Purchase of hearing aids is limited to \$1500 per ear every 60 months.

Questions? Call us at the number on the back of your ID card or visit us at www.bluecrossvt.org.

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 whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, contact 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	للحصول على خدمات المساعدة اللغوية المجانية ، اتصل (800) 247 2583 (TTY/TDD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).
CHINESE	如需免費語言支援服務，請致電 (800) 247-2583 TTY/TDD: 711).
CUSHITE (OROMO)	Tajaajila gargaarsa afaanii bilisaa argachuuf, (800) 247-2583 (TTY/TDD: 711) bilbili.
FRENCH	Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/TDD: 711).
GERMAN	Für kostenlose Sprachunterstützungsdienste rufen Sie (800) 247-2583 (TTY/TDD: 711) an.
ITALIAN	Per i servizi di assistenza linguistica gratuiti, chiamare il numero (800) 247- 2583 (TTY/TDD: 711).
JAPANESE	無料の言語支援サービスについては、 (800) 247-2583 (TTY/TDD: 711).

NEPALI	नःशुल्क 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).
PORTUGUESE	Para serviços gratuitos de assistência linguística, ligue para (800) 247-2583 (TTY/TDD: 711).
RUSSIAN	Чтобы получить бесплатную языковую помощь, позвоните по телефону (800) 247-2583 (TTY/TDD: 711).
SERBO-CROATIAN (SERBIAN)	За бесплатне услуге језичке помоћи позовите (800) 247-2583 (TTY/TDD: 711). Za besplatne usluge jezičke pomoći pozovite (800) 247-2583 (TTY/TDD: 711).
SPANISH	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583 (TTY/TDD: 711).

THAI

สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร, (800) 247-2583 (TTY/TDD: 711). Sǎhṛab brikār ch̄wyhēlūx đān phās̄ā frī thor (800) 247-2583 (TTY/TDD: 711).

UKRAINIAN

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

Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).

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