



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% co-insurance 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 not 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 deductible is not included in your out-of-pocket limit.

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, co-insurance, or co-payments 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 co-payment per visit Specialist: \$30 co-payment per visit MH/SUD primary: No charge MH/SUD specialist: No charge Physical, speech, occupational therapy: \$25 co-payment 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 co-payment 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 co-payment 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 co-payment per visit Provider: No charge MH/SUD facility: \$75 co-payment 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 co-payment per admission Provider: No charge MH/SUD inpatient: No charge Physical, speech, occupational therapy: \$25 co-payment per visit Outpatient provider: No charge. Outpatient surgery facility: No charge Diagnostic services: No charge Advanced imaging: \$30 co-payment 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 co-payment 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 co-payment per visit	
Care During Pregnancy Maternity care for mother and child	Inpatient delivery: \$250 co-payment 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 co-payment per visit Pulmonary: \$20 co-payment per visit	You must get prior approval for inpatient rehabilitation, see your Summary Plan Description for full details.
Telemedicine	Acute care: \$25 co-payment per visit MH/SUD: No charge Nutritional counseling: \$30 co-payment per visit Lactation consultation: \$30 co-payment 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 co-payment 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.
VisionCare Routine exam to determine visual problems and prescribe any necessary lenses Coverage for prescription or fitting of eyeglasses or contact lenses. Hearing Aids May be purchased from a clinical provider or over the counter, in- or out-of-network. Cost reimbursed through claim submission.	Pediatric exam: No charge Pediatric materials: No charge Adult exam: No charge Adult materials: No charge The benefit provided is up to \$1,500 per ear, every 60 months. No co-pay or deductible is charged.	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, co-payments, co-insurance, or out-of-pocket limits.

Pharmacy-Retail and home delivery co-payment

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.	

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.