# TotalChoice Plan: 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:** $300 individual/ $600 family per plan year. 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. For family plans at least one family member must satisfy the individual deductible limit. Then, the eligible medical expenses of other family members are aggregated until the family deductible is reached.

**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:** $750 individual / $2,250 family per plan year. Your deductible is 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?** No

**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**

For many services you may use any provider. For emergency care, you may use participating or non-participating providers and obtain benefits. However, in cases of emergency or services provided at a participating facility, non-participating providers are prohibited from billing you for amounts beyond the cost-sharing amounts without your permission, which you are not obligated to give. 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 a non-participating 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 Traditional. Please refer to your Summary Plan Description, Chapter One, “General Guidelines” on how to access care and choose a network provider. Please call our customer service team at the number listed on the back of your ID card if you need help selecting a provider.

| Service or Supply | Your cost when you use participating providers | Restrictions, limitations or other important information * |
|---|---|---|
| **Preventive Care**<br>Well-child care and immunizations<br>Annual OB-GYN exam<br>Preventive care includes routine immunizations, pap tests, preventive laboratory, screening mammograms, colorectal screening and X-rays. | **Office visits:** No charge | For screening mammograms, you may use participating or non-participating providers and obtain participating benefits. Preventive care benefits must meet the plan's definition of screening/preventive. For clarification on preventive services visit www.bluecrossvt.org/preventive. |
| **Office Visits**<br>Office examinations, diagnosis and treatment of an injury or illness, and allergy shots<br>Specialty provider's office<br>Care by specialists (e.g. cardiologist, oncologist)<br>Certain short-term therapies (e.g. physical, speech, occupational)<br>Surgery, lab, X-rays, allergy tests, other diagnostic services | **Primary care provider**: Deductible, then 20% coinsurance<br>**Specialist:** Deductible, then 20% coinsurance<br>**MH/SUD primary:** No charge<br>**MH/SUD specialist:** No charge<br>**Physical, speech, occupational therapy:** Deductible, then 20% coinsurance<br>**Surgery:** Deductible, then 20% coinsurance<br>**Diagnostic services:** Deductible, then 20% coinsurance<br>**Injections other than immunizations and allergy shots:** Deductible, then 20% coinsurance<br>**Other treatments:** Deductible, then 20% coinsurance | 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 habilitative 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. |
| **Acupuncture** | Deductible, then 20% coinsurance | This plan provides benefits for acupuncture services. Non-participating providers may bill you for the difference between the allowance and their charge. |
| **Ambulance Services**<br>Ambulance service to the nearest Facility in an emergency<br>Non-emergency transfer between facilities<br>Your condition must meet the criteria for an emergency medical condition as listed in your Summary Plan Description. | Deductible, then 20% coinsurance | All non-emergency ambulance transport requires prior approval. For ambulance services, you may use participating and non-participating providers and obtain participating benefits. |
| **Chiropractic Care**<br>Services to treat a neuromusculoskeletal condition | Deductible, then 20% coinsurance | Outpatient physical, occupational, speech therapy and chiropractic benefits are covered up to 60 visits combined, per plan year. |
| **Dental, Adult** | 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. |

| Service or Supply | Your cost when you use participating 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**<br>Hospital emergency room<br>Emergency provider<br>Mental health (MH) and substance use disorder (SUD) treatment | **Facility:** Deductible, then 20% coinsurance<br>**Provider:** Deductible, then 20% coinsurance<br>**MH/SUD facility:** Deductible, then 20% coinsurance<br>**MH/SUD provider:** Deductible, then 20% coinsurance | Your condition must meet the criteria for an emergency medical condition. For emergency care, you may use participating or non-participating providers and obtain network benefits. See your Summary Plan Description for more details. |
| **Home Care**<br>Skilled nursing visits, short-term therapy, private duty nursing<br>Infusion therapy<br>Hospice | **Home health:** Deductible, then 20% coinsurance<br>**Hospice:** Deductible, then 20% coinsurance<br>**Physical, speech, occupational therapy:** Deductible, then 20% coinsurance | 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 habilitative 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**<br>**Inpatient Care in a Hospital**<br>Appropriate room and board accommodations<br>All covered providers' services, including surgery<br>Mental health (MH) and substance use disorder (SUD) treatment<br>**Outpatient Care in a Hospital**<br>Outpatient surgery<br>Labs, X-rays, EKG and other diagnostic services<br>Physical, speech, occupational therapy<br>Other outpatient Services<br>Advanced imaging (e.g. MRI, CT scan, PET scan, Echo)<br>Mental health (MH) and substance use disorder (SUD) treatment | **Facility:** Deductible, then 10% coinsurance<br>**Provider:** Deductible, then 10% coinsurance<br>**MH/SUD inpatient:** No charge<br>**Physical, speech, occupational therapy:** Deductible, then 20% coinsurance<br>**Outpatient provider:** Deductible, then 20% coinsurance<br>**Outpatient surgery facility:** Deductible, then 20% coinsurance<br>**Diagnostic services:** Deductible, then 20% coinsurance<br>**Advanced imaging:** Deductible, then 20% coinsurance<br>**MH/SUD outpatient primary:** No charge<br>**MH/SUD outpatient specialist:** No charge<br>**MH/SUD intensive outpatient:** No charge | 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 habilitative 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. MH/SUD outpatient services with non-participating provider: Deductible, then 20% coinsurance. Inpatient and intensive outpatient services with non-participating provider: Deductible, then 10% coinsurance. For a list of primary care mental health and substance use disorder services visit www.bluecrossvt.org/members/coverage#expandable-section-6195 |
| **Medical Equipment and Supplies**<br>Supplies and equipment that are primarily and customarily used only for a medical purpose. | Deductible, then 20% coinsurance | Some medical equipment and supplies may require prior approval. |

| Service or Supply | Your cost when you use participating providers | Restrictions, limitations or other important information * |
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| **Nutritional Counseling** | Deductible, then 20% coinsurance | See your Summary Plan Description for more details. |
| **OB-GYN Office Visits**<br>Gynecological care | Deductible, then 20% coinsurance | |
| **Care During Pregnancy**<br>Maternity care for mother and child | **Inpatient delivery:** Deductible, then 10% coinsurance<br>**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**<br>Inpatient treatment<br>Outpatient cardiac or pulmonary rehabilitation | **Inpatient:** Deductible, then 10% coinsurance<br>**Cardiac:** Deductible, then 20% coinsurance<br>**Pulmonary:** Deductible, then 20% coinsurance | You must get prior approval for inpatient rehabilitation, see your Summary Plan Description for full details. |
| **Telemedicine** | **Acute care:** Deductible, then 20% coinsurance<br>**MH/SUD:** No charge<br>**Nutritional counseling:** Deductible, then 20% coinsurance<br>**Lactation consultation:** Deductible, then 20% coinsurance | For telemedicine consultations with a provider, visit www.bluecrossvt.org/find-doctor/telemedicine-care. For telemedicine consultations with a participating provider, see service or supply in this document for payment terms and limitations. |
| **Transplant Care**<br>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 participating providers. | Prior approval is required for all transplants except for kidney and cornea. Please see your Summary Plan Description for full details. |
| **Urgent Care**<br>Applies to urgent care facilities<br>Includes provider and facility services | Deductible, then 20% coinsurance | For urgent care facilities, you may use participating and non-participating providers and obtain participating benefits. See your Summary Plan Description for more details. |

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| **Vision Care**<br>Routine exam to determine visual problems and prescribe any necessary lenses<br>Coverage for prescription or fitting of eyeglasses or contact lenses | **Pediatric exam:** No charge<br>**Pediatric materials:** No charge<br>**Adult exam:** No charge<br>**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 | | |
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| 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](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).**

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| 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). |

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| 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 | निःशुल्क 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). |

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| 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). S̄ảhrạb brikār ch̀wyh̄elụ̄x dān p̣hās̄ā 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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