

TotalChoice Plan: State of Vermont

Outline of Coverage

[Download the full coverage of services document](#)

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 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 are: Outline of Coverage, State of Vermont Plan Document, Lost or Stolen Medical Equipment and Supplies Benefits, Telemedicine program benefits (V), Telemedicine services benefits (M)

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.bcbsvt.com/findadoctor and choose "Providers and Hospitals in Vermont Service Area." For a list of national, BlueCard providers, visit www.bcbsvt.com/findadoctor 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 Plan Document, 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
<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 participating or non-participating providers and obtain network benefits. Preventive care benefits must meet the plan's definition of screening/preventive. For clarification on preventive services visit www.bcbsvt.com/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: Deductible, then 20% co-insurance Specialist: Deductible, then 20% co-insurance MH/SUD outpatient primary: No charge MH/SUD outpatient specialist: No charge Physical, speech, occupational therapy: Deductible, then 20% co-insurance Surgery: Deductible, then 20% co-insurance Diagnostic Services: Deductible, then 20% co-insurance Injections other than immunizations and allergy shots: Deductible, then 20% co-insurance Other Treatments: Deductible, then 20% co-insurance</p>	<p>See your Plan Document 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.</p>
<p>Acupuncture</p>	<p>Deductible, then 20% co-insurance</p>	<p>This plan provides benefits for acupuncture services. Non-participating providers may bill you for the difference between the allowance and their charge</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 Plan Document</p>	<p>Deductible, then 20% co-insurance</p>	<p>All non-emergency ambulance transport requires prior approval. For ambulance services, you may use participating and non-participating providers and obtain network benefits.</p>
<p>Chiropractic Care Services to treat a neuromusculoskeletal condition</p>	<p>Deductible, then 20% co-insurance</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 Plan Document for more details.</p>

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 Plan Document for more details.
Emergency Care Hospital emergency room Emergency provider Mental health (MH) and substance use disorder (SUD) treatment	Facility: Deductible, then 20% co-insurance Provider: Deductible, then 20% co-insurance MH/SUD facility: Deductible, then 20% co-insurance MH/SUD provider: Deductible, then 20% co-insurance	Your condition must meet the criteria for an emergency medical condition. See your Plan Document for more details. For emergency care, you may use participating or non-participating providers and obtain network benefits.
Home Care Skilled nursing visits, short-term therapy, private duty nursing Infusion therapy Hospice	Home health: Deductible, then 20% co-insurance Hospice: Deductible, then 20% co-insurance Physical, speech, occupational therapy: Deductible, then 20% co-insurance	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 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: Deductible, then 10% co-insurance Provider: Deductible, then 10% co-insurance MH/SUD inpatient: No charge Physical, speech, occupational therapy: Deductible, then 20% co-insurance Outpatient provider: Deductible, then 20% co-insurance Outpatient surgery facility: Deductible, then 20% co-insurance Diagnostic services: Deductible, then 20% co-insurance Advanced imaging: Deductible, then 20% co-insurance MH/SUD outpatient primary: No charge MH/SUD outpatient specialist: No charge 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. Some outpatient services require prior approval. MH/SUD outpatient services with non-participating provider: Deductible, then 20% co-insurance Inpatient and intensive outpatient services with non-participating provider: Deductible, then 10% co-insurance. For a list of primary care mental health and substance abuse services visit www.bcbsvt.com/mental-health-primary-care .

Service or Supply	Your cost when you use participating providers	Restrictions, limitations or other important information
Medical Equipment and Supplies Supplies and equipment that are primarily and customarily used only for a medical purpose.	Deductible, then 20% co-insurance	Some medical equipment and supplies may require prior approval.
Nutritional Counseling	Deductible, then 20% co-insurance	See your Plan Document for more details.
OB-GYN Office Visits Gynecological care	Office visit: Deductible, then 20% co-insurance	
Care During Pregnancy Maternity care for mother and child	Inpatient delivery: Deductible, then 10% co-insurance Office visit: No charge	Your plan covers preventive prenatal and post-natal 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: Deductible, then 10% co-insurance Cardiac/Pulmonary: Deductible, then 20% co-insurance	You must get prior approval for inpatient rehabilitation, see your Plan Document for full details.
Telemedicine Services	Acute care: Deductible, then 20% co-insurance MH/SUD: No charge Lactation consultation: Deductible, then 20% co-insurance Nutritional counseling: Deductible, then 20% co-insurance	For telemedicine consultations with an Amwell provider, visit www.Amwell.com . 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 Plan Document for full details.
Urgent Care Applies to urgent care facilities Includes provider and facility services	Deductible, then 20% co-insurance	For urgent care facilities, you may use participating and non-participating providers and obtain the same level of benefits. See your Plan Document 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 vision 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 Plan Document 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 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.	
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This plan provides benefits for select infertility services. Please refer to your Plan Document 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 calendar year.

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