BlueCross BlueShield of Vermont

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 overall out-of-pocket limit and out-of-network out-of-pocket limit are combined.

Your out-of-network out-of-pocket limit is: $1,500 individual / $3,000 family per plan year. Your overall out-of-pocket limit and out-of-network out-of-pocket limit are 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 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

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 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.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 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 Plan Document, Chapter One, "General Guidelines" on how to access care and choose a network provider.

Service or Supply	Your cost when you use providers	Restrictions, limitations or other important information
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.	**Office visits:** No charge	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.bcbsvt.com/ preventive.
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	**Primary care provider**: $25 co-payment per visit **Specialist**: $30 co-payment per visit **MH/SUD outpatient primary:** No charge **MH/SUD outpatient 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	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.
Acupuncture	$25 co-payment per visit	This plan provides benefits for acupuncture services. Services with a non-network provider are covered at your non-network provider benefit level.
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 in your Plan Document	No charge	All non-emergency ambulance transport requires prior approval. For ambulance services, you may use network and out-of-network providers and obtain network benefits.
Chiropractic Care Services to treat a neuromusculoskeletal condition	$25 co-payment per visit	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 Plan Document for more details.
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.

Service or Supply	Your cost when you use providers	Restrictions, limitations or other important information
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. See your Plan Document for more details. For emergency care, you may use network or out-of-network providers and obtain network benefits.
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 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:** $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 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.Your plan may apply multiple co-payments per visit.
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 Plan Document for more details.
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 visit **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.

Service or Supply	Your cost when you use providers	Restrictions, limitations or other important information
Rehabilitation and Skilled Nursing Facility Care Inpatient treatment Outpatient cardiac or pulmonary rehabilitation	**Inpatient:** No charge **Cardiac/Pulmonary:** $20 co-payment per visit	You must get prior approval for inpatient rehabilitation, see your Plan Document for full details.
Telemedicine	**Acute care:** $25 co-payment per visit **MH/SUD:** No charge **Lactation consultation:** $30 co-payment per visit **Nutritional counseling:** $30 co-payment per visit	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	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	$50 co-payment per visit	For urgent care facilities, you may use network and out-of-network providers and obtain network 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 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.	

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 plan year.

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