



# 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 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?** 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](http://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](http://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](http://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
<p><b>Preventive Care</b> 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><b>Office visits:</b> No charge</p>	<p>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 <a href="http://www.bluecrossvt.org/preventive">www.bluecrossvt.org/preventive</a>.</p>
<p><b>Office Visits</b> 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><b>Primary care provider:</b> Deductible, then 20% co-insurance <b>Specialist:</b> Deductible, then 20% co-insurance <b>MH/SUD primary:</b> No charge <b>MH/SUD specialist:</b> No charge <b>Physical, speech, occupational therapy:</b> Deductible, then 20% co-insurance <b>Surgery:</b> Deductible, then 20% co-insurance <b>Diagnostic services:</b> Deductible, then 20% co-insurance <b>Injections other than immunizations and allergy shots:</b> Deductible, then 20% co-insurance <b>Other treatments:</b> Deductible, then 20% co-insurance</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><b>Acupuncture</b></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><b>Ambulance Services</b> 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>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 participating benefits.</p>
<p><b>Chiropractic Care</b> 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><b>Dental, Adult</b></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 participating providers	Restrictions, limitations or other important information
<b>Dental, Pediatric</b>	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.
<b>Emergency Care</b> Hospital emergency room Emergency provider Mental health (MH) and substance use disorder (SUD) treatment	<b>Facility:</b> Deductible, then 20% co-insurance <b>Provider:</b> Deductible, then 20% co-insurance <b>MH/SUD facility:</b> Deductible, then 20% co-insurance <b>MH/SUD provider:</b> Deductible, then 20% co-insurance	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.
<b>Home Care</b> Skilled nursing visits, short-term therapy, private duty nursing Infusion therapy Hospice	<b>Home health:</b> Deductible, then 20% co-insurance <b>Hospice:</b> Deductible, then 20% co-insurance <b>Physical, speech, occupational therapy:</b> 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 rehabilitative therapy services. Therapy services provided as treatment for autism spectrum disorder are separate and require prior approval after 60 combined visits
<b>Care in a Hospital</b> <b>Inpatient Care in a Hospital</b> Appropriate room and board accommodations All covered providers' services, including surgery Mental health (MH) and substance use disorder (SUD) treatment <b>Outpatient Care in a Hospital</b> 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	<b>Facility:</b> Deductible, then 10% co-insurance <b>Provider:</b> Deductible, then 10% co-insurance <b>MH/SUD inpatient:</b> No charge <b>Physical, speech, occupational therapy:</b> Deductible, then 20% co-insurance <b>Outpatient provider:</b> Deductible, then 20% co-insurance <b>Outpatient surgery facility:</b> Deductible, then 20% co-insurance <b>Diagnostic services:</b> Deductible, then 20% co-insurance <b>Advanced imaging:</b> Deductible, then 20% co-insurance <b>MH/SUD outpatient primary:</b> No charge <b>MH/SUD outpatient specialist:</b> No charge <b>MH/SUD intensive outpatient:</b> 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 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. 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 use disorder services visit <a href="http://www.bluecrossvt.org/members/coverage#expandable-section-6195">www.bluecrossvt.org/members/coverage#expandable-section-6195</a>
<b>Medical Equipment and Supplies</b> 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.

Service or Supply	Your cost when you use participating providers	Restrictions, limitations or other important information
<b>Nutritional Counseling</b>	Deductible, then 20% co-insurance	See your Summary Plan Description for more details.
<b>OB-GYN Office Visits</b> Gynecological care	Deductible, then 20% co-insurance	
<b>Care During Pregnancy</b> Maternity care for mother and child	<b>Inpatient delivery:</b> Deductible, then 10% co-insurance <b>Office visit:</b> 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.
<b>Rehabilitation and Skilled Nursing Facility Care</b> Inpatient treatment Outpatient cardiac or pulmonary rehabilitation	<b>Inpatient:</b> Deductible, then 10% co-insurance <b>Cardiac:</b> Deductible, then 20% co-insurance <b>Pulmonary:</b> Deductible, then 20% co-insurance	You must get prior approval for inpatient rehabilitation, see your Summary Plan Description for full details.
<b>Telemedicine</b>	<b>Acute care:</b> Deductible, then 20% co-insurance <b>MH/SUD:</b> No charge <b>Nutritional counseling:</b> Deductible, then 20% co-insurance <b>Lactation consultation:</b> Deductible, then 20% co-insurance	For telemedicine consultations with a provider, visit <a href="http://www.bluecrossvt.org/find-doctor/telemedicine-care">www.bluecrossvt.org/find-doctor/telemedicine-care</a> . For telemedicine consultations with a participating provider, see service or supply in this document for payment terms and limitations.
<b>Transplant Care</b> 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.
<b>Urgent Care</b> 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 participating 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
<p><b>Vision Care</b>  Routine exam to determine visual problems and prescribe any necessary lenses  Coverage for prescription or fitting of eyeglasses or contact lenses</p>	<p><b>Pediatric exam:</b> No charge  <b>Pediatric materials:</b> No charge  <b>Adult exam:</b> No charge  <b>Adult materials:</b> No charge</p>	<p>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.</p>

### 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

<b>Generic Drugs</b>	Please refer to your separate pharmacy benefits manager for details on your pharmacy coverage.	
<b>Preferred Brand Drugs</b>	Please refer to your separate pharmacy benefits manager for details on your pharmacy coverage.	
<b>Non-Preferred Brand Drugs</b>	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 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](http://www.bluecrossvt.org).**