# Vermont Health Partnership (POS) 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:** Not applicable.

**Your other deductibles are:** $100 durable medical equipment and supplies deductible per member, per plan year. 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:** Not applicable.

**Your out-of-network out-of-pocket limit is:** $2,500 individual/$5,000 family per plan year. The out-of-pocket for network and out-of-network providers is separate.

**Your out-of-pocket limit for prescription drugs is:** $600 individual / $1,200 family per plan year prescription drug out-of-pocket limit.

**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 (Benefits 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 Benefits 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 |
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| **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:** $25 co-payment per visit | 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. |
| **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**: $15 co-payment per visit<br>**Specialist:** $25 co-payment per visit<br>**MH/SUD primary:** $15 co-payment per visit<br>**MH/SUD specialist:** $25 co-payment per visit<br>**Physical, speech, occupational therapy:** $25 co-payment per visit<br>**Surgery:** No charge<br>**Diagnostic services:** No charge<br>**Injections other than immunizations and allergy shots:** No charge<br>**Other treatments:** No charge | Certain provider specialties must be network or there is no benefit. See your Benefits Description for more details. Your plan limits outpatient rehabilitative physical, speech and occupational therapy benefits to 30 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 30 combined visits. Some surgeries and diagnostic services require prior approval. |
| **Acupuncture** | Not covered | |
| **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 Benefits Description. | $50 co-payment per member per day | 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**<br>Services to treat a neuromusculoskeletal condition | $25 co-payment per visit | You must use a network chiropractor. Requires prior approval after 12 visits per member, 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 Benefits Description 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 Benefits Description for more details. |

| Service or Supply | Your cost when you use network providers | Restrictions, limitations or other important information |
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| **Emergency Care**<br>Hospital emergency room<br>Emergency provider<br>Mental health (MH) and substance use disorder (SUD) treatment | **Facility:** No charge<br>**Provider:** No charge<br>**MH/SUD facility:** No charge<br>**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 Benefits Description for more details. |
| **Home Care**<br>Skilled nursing visits, short-term therapy, private duty nursing<br>Infusion therapy<br>Hospice | **Home health:** No charge<br>**Hospice:** No charge<br>**Physical, speech, occupational therapy:** No charge | Private duty nursing is covered up to 14 hours per member per plan year. Your plan limits outpatient rehabilitative physical, speech and occupational therapy benefits to 30 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 30 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:** No charge<br>**Provider:** No charge<br>**MH/SUD inpatient:** No charge<br>**Physical, speech, occupational therapy:** No charge<br>**Outpatient provider:** No charge.<br>**Outpatient surgery facility:** No charge<br>**Diagnostic services:** No charge<br>**Advanced imaging:** No charge<br>**MH/SUD outpatient primary:** $15 co-payment per visit<br>**MH/SUD outpatient specialist:** $25 co-payment per visit<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. Your plan limits outpatient rehabilitative physical, speech and occupational therapy benefits to 30 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 30 combined visits. Some outpatient services require prior approval. 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. | $100 Deductible, then 20% co-insurance | Some medical equipment and supplies may require prior approval. Diabetic medication and supplies are not subject to deductible, co-insurance, or co-payment. |
| **Nutritional Counseling** | $25 co-payment per visit | You must use a network nutritional counselor. See your Benefits Description for more details. |
| **OB-GYN Office Visits**<br>Gynecological care | $25 co-payment per visit | |

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| **Care During Pregnancy**<br>Maternity care for mother and child | **Inpatient delivery:** No charge<br>**Office visit:** $25 co-payment per visit | Other services and tests may take additional cost sharing. 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:** No charge<br>**Cardiac:** No charge<br>**Pulmonary:** No charge | You must get prior approval for inpatient rehabilitation, see your Benefits Description for full details. Certain provider specialties must be network or there is no benefit. This benefit does not cover care in an out-of-network physical rehabilitation facility. |
| **Telemedicine** | **Acute care:** $15 co-payment per visit<br>**MH/SUD:** $25 co-payment per visit<br>**Nutritional counseling:** $25 co-payment per visit<br>**Lactation consultation:** Not covered | 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**<br>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 Benefits Description for full details. |
| **Urgent Care**<br>Applies to urgent care facilities<br>Includes provider and facility services | $25 co-payment per visit | For urgent care facilities, you may use network and out-of-network providers and obtain network benefits. See your Benefits Description for more details. |
| **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:** $20 co-payment per visit<br>**Pediatric materials:** Not covered<br>**Adult exam:** $20 co-payment per visit<br>**Adult materials:** Not covered | For optometry services to treat a disease condition, please see your office visit benefit outlined above. One routine vision exam per member, per plan year. This benefit does not cover the evaluation and fitting of contact lenses or other supplemental tests. |

| How Your Pharmacy Coverage Works | | |
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| Some prescription drugs require prior approval. Visit www.bluecrossvt.org or call customer service for the list. Benefits provided for up to a 90-day supply for most prescription drugs. You must use a network pharmacy. Find a network pharmacy at https://www.bluecrossvt.org/pharmacies-medications. This plan follows the National Performance Formulary (NPF). For more information about your prescription drug coverage, please visit https://www.bluecrossvt.org/pharmacies-medications. | | |
| Pharmacy-Retail and home delivery co-payment | | |
| Generic Drugs | Retail:<br>$5 per 30-day supply; $15 per 90-day supply<br>Home delivery pharmacy:<br>$5 per 30-day supply; $15 per 90-day supply | $600 individual/ $1,200 family per plan year prescription drug out-of-pocket limit. No charge for diabetic medications and supplies obtained through your prescription drug benefit. |
| Preferred Brand Drugs | Retail:<br>$20 per 30-day supply; $60 per 90 day supply<br>Home delivery pharmacy:<br>$20 per 30-day supply; $60 per 90-day supply | |
| Non-Preferred Brand Drugs | Retail:<br>$45 per 30-day supply; $135 per 90-day supply<br>Home delivery pharmacy:<br>$45 per 30-day supply; $135 per 90-day supply | |
| Wellness Drugs | | |
| | Wellness drugs process the same as any other prescription, as outlined above. | $600 Individual / $1,200 family per plan year prescription drug out-of-pocket limit. No charge for diabetic medications and supplies obtained through your prescription drug benefit. |



**Questions? Call us at the number on the back of your ID card or visit us at www.bluecrossvt.org.**