VEHI Gold CDHP - Consumer Directed Health Plan (CDHP) - Exclusive Provider Organization (PCP) 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: $1,800 individual/ $3,600 family per plan year. For a family contract, the family deductible must be met before the plan pays benefits. You have an aggregate overall deductible.

Your prescription drug deductible is: Your plan combines your prescription drug and medical deductibles.

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: $2,500 individual / $5,000 family per plan year. Your copayments are included in your overall out-of-pocket limit. Your plan combines your prescription drug and medical out-of-pocket limits. You have an aggregate overall out-of-pocket limit.

Your out-of-pocket limit for prescription drugs is: $1,650 individual / $3,300 family per plan year prescription drug out-of-pocket limit. You have an aggregate prescription drug out-of-pocket limit. Your plan combines your prescription drug and medical out-of-pocket limits.

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

You must use a network provider or there is no benefit. 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. In other circumstances, you must get prior approval for out-of-network, non-emergency care. 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 *
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	Preventive care benefits must meet the plan's definition of screening/preventive. For clarification on preventive services visit www.bluecrossvt.org/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**: Deductible, then 20% coinsurance **Specialist:** Deductible, then 20% coinsurance **MH/SUD primary:** Deductible, then 20% coinsurance **MH/SUD specialist:** Deductible, then 20% coinsurance **Physical, speech, occupational therapy:** Deductible, then 20% coinsurance **Surgery:** Deductible, then 20% coinsurance **Diagnostic services:** Deductible, then 20% coinsurance **Injections other than immunizations and allergy shots:** Deductible, then 20% coinsurance **Other treatments:** Deductible, then 20% coinsurance	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 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 Benefits Description.	Deductible, then 20% coinsurance	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	Deductible, then 20% coinsurance	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 *
Emergency Care Hospital emergency room Emergency provider Mental health (MH) and substance use disorder (SUD) treatment	**Facility:** Deductible, then 20% coinsurance **Provider:** Deductible, then 20% coinsurance **MH/SUD facility:** Deductible, then 20% coinsurance **MH/SUD provider:** Deductible, then 20% coinsurance	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 Skilled nursing visits, short-term therapy, private duty nursing Infusion therapy Hospice	**Home health:** Deductible, then 20% coinsurance **Hospice:** Deductible, then 20% coinsurance **Physical, speech, occupational therapy:** Deductible, then 20% coinsurance	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 **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 20% coinsurance **Provider:** Deductible, then 20% coinsurance **MH/SUD inpatient:** Deductible, then 20% coinsurance **Physical, speech, occupational therapy:** Deductible, then 20% coinsurance **Outpatient provider:** Deductible, then 20% coinsurance **Outpatient surgery facility:** Deductible, then 20% coinsurance **Diagnostic services:** Deductible, then 20% coinsurance **Advanced imaging:** Deductible, then 20% coinsurance **MH/SUD outpatient primary:** Deductible, then 20% coinsurance **MH/SUD outpatient specialist:** Deductible, then 20% coinsurance **MH/SUD intensive outpatient:** Deductible, then 20% coinsurance	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 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.
Nutritional Counseling	Deductible, then 20% coinsurance	You must use a network nutritional counselor. See your Benefits Description for more details.

Service or Supply	Your cost when you use network providers	Restrictions, limitations or other important information *
OB-GYN Office Visits Gynecological care	Deductible, then 20% coinsurance	
Care During Pregnancy Maternity care for mother and child	**Inpatient delivery:** Deductible, then 20% coinsurance **Office visit:** Deductible, then 20% coinsurance	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 Inpatient treatment Outpatient cardiac or pulmonary rehabilitation	**Inpatient:** Deductible, then 20% coinsurance **Cardiac:** Deductible, then 20% coinsurance **Pulmonary:** Deductible, then 20% coinsurance	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:** Deductible, then 20% coinsurance **MH/SUD:** Deductible, then 20% coinsurance **Nutritional counseling:** Deductible, then 20% coinsurance **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 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 Benefits Description for full details.
Urgent Care Applies to urgent care facilities Includes provider and facility services	Deductible, then 20% coinsurance	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 Routine exam to determine visual problems and prescribe any necessary lenses Coverage for prescription or fitting of eyeglasses or contact lenses	**Pediatric exam:** $20 copayment per visit **Pediatric materials:** Not covered **Adult exam:** $20 copayment per visit **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		
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 copayment		
Generic Drugs	Deductible, then **Retail:** 20% coinsurance **Home delivery pharmacy:** 20% coinsurance	This benefit combines your prescription drug and medical deductibles. $1,650 Individual /$3,300 family per plan year prescription drug out-of-pocket limit. Your plan combines your prescription drug and medical out-of-pocket limits. No charge for diabetic medications and supplies obtained through your prescription drug benefit.
Preferred Brand Drugs	Deductible, then **Retail:** 20% coinsurance **Home delivery pharmacy:** 20% coinsurance	
Non-Preferred Brand Drugs	Deductible, then **Retail:** 20% coinsurance **Home delivery pharmacy:** 20% coinsurance	
Wellness Drugs		
	No charge	Deductible does not apply to wellness drugs. $1,650 Individual /$3,300 family per plan year prescription drug out-of-pocket limit.Your plan combines your prescription drug and medical out-of-pocket limits. No charge for diabetic medications and supplies obtained through your prescription drug benefit.

*Under certain circumstances, when ordered by a primary care physician, the prior authorizations indicated in this chart would not be applicable.

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**.

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: Kienan D. Christianson, 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, Kienan D. Christianson, 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).

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).
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	नःशुल्क 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).
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). S̄ảhr̄ạb brikār ch̀wyh̄elụ̄x ďān 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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