Comprehensive Plan - $300 Deductible 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.

Your prescription drug deductible is: Not applicable.

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: $600 individual / $1,200 family per plan year.

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? 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 (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

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 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 Traditional. Please refer to your Benefits 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
Preventive Care Well-child care and immunizations Annual OB-GYN exam Preventive care includes screening mammograms and colorectal screening.	**Office visits:** Deductible, then 20% coinsurance	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 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% co-insurance **Specialist:** Deductible, then 20% co-insurance **MH/SUD primary:** Deductible, then 20% co-insurance **MH/SUD specialist:** Deductible, then 20% co-insurance **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	Certain provider specialties must be participating 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% co-insurance	All non-emergency ambulance transport requires prior approval. For ambulance services, you may use participating and non-participating providers and obtain participating benefits.
Chiropractic Care Services to treat a neuromusculoskeletal condition	Deductible, then 20% co-insurance	You must use a participating 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 participating 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% 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. For emergency care, you may use participating or non-participating 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% co-insurance **Hospice:** Deductible, then 20% co-insurance **Physical, speech, occupational therapy:** Deductible, then 20% co-insurance	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% co-insurance **Provider:** Deductible, then 20% co-insurance **MH/SUD inpatient:** Deductible, then 20% co-insurance **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:** Deductible, then 20% co-insurance **MH/SUD outpatient specialist:** Deductible, then 20% co-insurance **MH/SUD intensive outpatient:** Deductible, then 20% co-insurance	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% co-insurance	Some medical equipment and supplies may require prior approval.
Nutritional Counseling	Deductible, then 20% co-insurance	You must use a participating nutritional counselor. See your Benefits Description for more details.

Service or Supply	Your cost when you use participating providers	Restrictions, limitations or other important information
OB-GYN Office Visits Gynecological care	Deductible, then 20% co-insurance	
Care During Pregnancy Maternity care for mother and child	**Inpatient delivery:** Deductible, then 20% co-insurance **Office visit:** Deductible, then 20% co-insurance	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% co-insurance **Cardiac:** Deductible, then 20% co-insurance **Pulmonary:** Deductible, then 20% co-insurance	You must get prior approval for inpatient rehabilitation, see your Benefits Description for full details. Certain provider specialties must be participating or there is no benefit. This benefit does not cover care in a non-participating physical rehabilitation facility.
Telemedicine	**Acute care:** Deductible, then 20% co-insurance **MH/SUD:** Deductible, then 20% co-insurance **Nutritional counseling:** Deductible, then 20% co-insurance **Lactation consultation:** Not covered	For telemedicine consultations with a provider, visit www.bluecrossvt.org/find-doctor/telemedicine-care. For telemedicine consultations with a participating 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 participating 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% co-insurance	For urgent care facilities, you may use participating and non-participating providers and obtain participating 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:** Not covered **Pediatric materials:** Not covered **Adult exam:** Not covered **Adult materials:** Not covered	For optometry services to treat a disease condition, please see your office visit benefit outlined above. 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 co-payment		
Generic Drugs	Retail: $5 per 30-day supply; $15 per 90-day supply Home delivery pharmacy: $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: $20 per 30-day supply; $60 per 90 day supply Home delivery pharmacy: $20 per 30-day supply; $60 per 90-day supply	
Non-Preferred Brand Drugs	Retail: $45 per 30-day supply; $135 per 90-day supply Home delivery pharmacy: $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.