BlueCross BlueShield of Vermont

Coverage for: FIRST NAME, LAST NAME [XXX100000000001]
Coverage Period Begins: 9999-01-01
Your Plan Year begins the first day of: January

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. 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 co-payments 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: $1,400 individual / $2,800 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 are: Outline of Coverage, VEHI Gold and Silver Exclusive Provider Organization PCP CDHP Benefits Description

Provider Network Information

You must use a network provider or there is no benefit. In the case of an emergency, seek care right away. For emergency care, you may use network or non-network providers and obtain network benefits. You must get prior approval for non-network, non-emergency care. If you use a non-network provider for non-emergency care, you may be billed the difference between the allowed amount and billed charges. The difference between the allowed amount and billed charges 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 Benefits Description, Chapter One, "General Guidelines" for details 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.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:** 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 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 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 network and non-network providers and obtain network benefits.
Chiropractic Care Services to treat a neuromusculoskeletal condition	Deductible, then 20% co-insurance	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.

Service or Supply	Your cost when you use network providers	Restrictions, limitations or other important information
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.
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. See your Benefits Description for more details. For emergency care, you may use network or non- network providers and obtain network benefits.
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 primary:** Deductible, then 20% co-insurance **MH/SUD 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.bcbsvt.com/mental-health-primary-care.

Service or Supply	Your cost when you use network providers	Restrictions, limitations or other important information
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 network nutritional counselor. Nutritional counseling benefits are covered up to three visits per member, per plan year. There is no limit on the number of nutritional counseling visits for treatment of diabetes. See your Benefits Description for more details.
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	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.
Rehabilitation and Skilled Nursing Facility Care Inpatient treatment Outpatient cardiac or pulmonary rehabilitation	**Inpatient:** Deductible, then 20% co-insurance **Cardiac/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 network or there is no benefit. This benefit does not cover care in a non-network physical rehabilitation facility.
Telemedicine Services	**Acute care:** Deductible, then 20% co-insurance **MH/SUD:** Deductible, then 20% co-insurance **Nutritional counseling:** Deductible, then 20% co-insurance **Lactation consultation:** Deductible, then 20% co-insurance	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 may be required.
Urgent Care Applies to urgent care facilities Includes provider and facility services	Deductible, then 20% co-insurance	For urgent care facilities, you may use network and non-network providers and obtain network benefits. See your Benefits Description for more details.

Service or Supply	Your cost when you use network providers	Restrictions, limitations or other important information
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 co-payment per visit **Pediatric materials:** Not covered **Adult exam:** $20 co-payment 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.bcbsvt.com 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 www.bcbsvt.com/findadoctor. This plan follows the National Performance Formulary (NPF). For more information about your prescription drug coverage, please visit www.bcbsvt.com/rxcenter.

Pharmacy-Retail and home delivery copayment		
Generic Drugs	Deductible, then **Retail:** 20% co-insurance **Home delivery pharmacy:** 20% co-insurance	This benefit combines your prescription drug and medical deductibles. $1,400 individual / $2,800 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% co-insurance **Home delivery pharmacy:** 20% co-insurance	This benefit combines your prescription drug and medical deductibles. $1,400 individual / $2,800 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.
Non-Preferred Brand Drugs	Deductible, then **Retail:** 20% co-insurance **Home delivery pharmacy:** 20% co-insurance	This benefit combines your prescription drug and medical deductibles. $1,400 individual / $2,800 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.

Wellness Drugs		
	No charge	Deductible does not apply to wellness drugs. $1,400 individual / $2,800 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.

Questions? Call us at the number on the back of your ID card or visit us at www.[illegible]svt.com.