BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

vehi

Gold CDHP Exclusive Provider Organization PCP Outline of Coverage

Coverage Period Begins: January 1

This is an outline of your coverage. For full benefit details, please read your entire benefits description. Blue Cross and Blue Shield of Vermont provides administrative services and does not assume any financial risk for claims.

Deductible (aggregate)

- $1,800 if you have an individual plan
- $3,600 if you have a two-person, parent and child(ren) or family plan
- Your deductible applies to covered medical and prescription drug services and supplies.

Prescription drug out-of-pocket limit (aggregate)

- $1,350 if you have an individual plan
- $2,700 if you have a two-person, parent and child(ren) or family plan
- Your prescription drug out-of-pocket limit accrues towards your total out-of-pocket limit.

Total out-of-pocket limit (aggregate)

- $2,500 if you have an individual plan
- $5,000 if you have a two-person, parent and child(ren) or family plan
- Your out-of-pocket limit applies to covered medical and prescription drug services and supplies.

Federal guidelines require your newborn or adopted child to meet their own deductible for covered services beginning on their date of birth.

Do you need a primary care provider? Yes.

Do you need a referral to see a specialist? No, but some services require prior approval from BCBSVT.

Does prior approval apply? Yes, some services listed in this document require prior approval. For these services, your network provider will request prior approval for you. If you do not receive prior approval, your plan will not cover your care. For the most up-to-date prior approval list, please visit **www.bcbsvt.com/priorapproval.**

Your plan documents are: This outline of coverage and your VEHI Gold and Silver CDHP Exclusive Provider Organization PCP benefits description.

Understanding your network: The benefits listed on this outline of coverage, and in your benefits description, apply when you use network providers. Please refer to Chapter One, Guidelines for Coverage for more details.

BCBSVT Network providers: Locally, you must use our BCBSVT Network providers. Our BCBSVT Network providers are located in Vermont and contiguous counties. To find a BCBSVT Network provider visit **www.bcbsvt.com/findadoctor** or call the number listed on the back of your ID card.

Blue Card providers: Nationally and internationally, you must use the BCBS EPO/PPO network. Use this network if you are seeking services outside of the BCBSVT Network in Vermont and contiguous counties. To find a Blue Card provider 24 hours a day, seven days a week, please visit **provider.bcbs.com** or call (800) 810-BLUE (2583).

Emergency care and urgent care: You do not need to see a network provider for emergency or urgent care services (as defined in your benefits description). In these situations, please seek care immediately. If a non-network provider balance bills you for emergency or urgent care services, please call BCBSVT's customer service team at the number listed on the back of your ID card.

Non-network care: Non-network care is care you receive from a provider or facility that does not contract with BCBSVT, or with any other Blue plan, and is therefore not in the local BCBSVT Network or the national EPO/PPO network. You must get prior approval for all non-network care. Even if you receive prior approval for non-network services, you may be billed the difference between the allowed amount and billed charges. The amount you pay to a non-network provider, above the allowed amount, does not accumulate toward your plan year out-of-pocket limit.

Service or supply	Your cost when you use network providers	Restrictions, limitations or other important information
Preventive Care ■ Well-child care, immunizations and physical examinations ■ Annual OB-GYN exam ■ Routine immunizations, pap tests, preventive laboratory and X-rays ■ Maternity care for mother and child	No cost to you.	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 ■ Mental health and substance abuse services (MH/SA) ■ Specialty provider's office ■ Care by specialists (e.g. cardiologist, oncologist) ■ Certain short-term therapies **Other** ■ Surgery, lab, X-rays, allergy tests, other diagnostics ■ Injections other than immunizations and allergy shots	PCP office visits: Deductible, then 20% co-insurance MH/SA PCP office visit: Deductible, then 20% co-insurance Specialist office visits: Deductible, then 20% co-insurance Short-term therapies (PT/OT/ST): Deductible, then 20% co-insurance Other: Deductible, then 20% co-insurance	You must use a network provider or your plan will not cover your care. Please see your benefits description for details. Your plan covers up to 30 combined visits for outpatient physical, speech and occupational therapy benefits per member, per plan year. Your plan has a separate, but equal, visit limit for habilitative services.
Ambulance Services ■ Ambulance service to the nearest facility in an emergency ■ Non-emergency transfer between facilities ■ For ambulance services, you may use network and non-network providers and obtain network benefits	Deductible, then 20% co-insurance	Your condition must meet the criteria for an emergency medical condition as defined in your benefits description. All non-emergency ambulance transport requires prior approval. You must get prior approval within 48 hours of emergency air or water transport.
Chiropractic Care ■ Services to treat a neuromusculoskeletal condition	Deductible, then 20% co-insurance	Your plan requires prior approval after 12 chiropractic visits per plan year.
Emergency Care ■ Hospital emergency room ■ Emergency provider	Facility: Deductible, then 20% co-insurance Provider: Deductible, then 20% co-insurance	Your condition must meet the criteria for an emergency medical condition as listed in your benefits description.
Home Care ■ Home health, skilled nursing visits, short-term therapy, private duty nursing ■ Infusion therapy ■ Hospice	Deductible, then 20% co-insurance	Your plan covers up to 30 visits for outpatient physical, speech and occupational therapy benefits per member, per plan year. Your plan has a separate, but equal, visit limit for habilitative services. Your plan covers up to 14 hours of private duty nursing per member, per plan year.
Inpatient Care in a Hospital ■ Appropriate room and board accommodations ■ All covered providers' services, including surgery ■ Maternity care for mother and child ■ Mental health and substance abuse treatment	Facility: Deductible, then 20% co-insurance Provider: Deductible, then 20% co-insurance	If you're expecting, please visit **www.bcbsvt.com/betterbeginnings.**
Outpatient Care in a Hospital ■ Outpatient surgery ■ Mental health and substance abuse treatment ■ Physical, speech, occupational therapy (PT/OT/ST) **Other** ■ Labs, X-rays, EKG and other diagnostic services ■ High dollar imaging (e.g. MRI, CT scan, PET scan)	Facility: Deductible, then 20% co-insurance Provider: Deductible, then 20% co-insurance PT/OT/ST: Deductible, then 20% co-insurance Other: Deductible, then 20% co-insurance	Your plan covers up to 30 combined visits for outpatient physical, speech and occupational therapy benefits per member, per plan year. Your plan has a separate, but equal, visit limit for habilitative services.

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	
Nutritional Counseling	Deductible, then 20% co-insurance	Your plan covers up to three visits per member, per plan year. If you have diabetes, your plan does not limit the amount of visits you may use for treatment of diabetes. If you have a diagnosis of a metabolic disease, or an eating disorder, you may request prior approval for additional visits.
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. For more information please visit **www.bcbsvt.com/preventive.** Members enrolled in our better beginnings program receive additional perks. Please visit **www.bcbsvt.com/betterbeginnings.**
Rehabilitation and Skilled Nursing Facility Care ▪ Inpatient treatment ▪ Outpatient cardiac or pulmonary rehabilitation	Deductible, then 20% co-insurance	
Telemedicine Services Program	Deductible, then 20% co-insurance	Blue Cross and Blue Shield of Vermont (BCBSVT) has contracted with the independent company, American Well® (Amwell) to provide mobile, telemedicine services for BCBSVT members. For more information, please visit **amwell.com**. For telemedicine consultations with a network provider, other than Amwell, see service or supply in this document for payment terms.
Transplant Care ▪ Benefits for transplant related office visits, diagnostic services, surgeries and Inpatient care	Cost-sharing amounts vary	Use this grid to find the appropriate service or supply you're seeking related to transplant care. This will help you understand your cost-sharing requirements.
Urgent Care ▪ Applies to urgent care facilities. ▪ Includes provider and facility services.	Deductible, then 20% co-insurance	For urgent care in a facility, you may use network and non-network providers and obtain network benefits.
Vision Services ▪ Routine exam to determine visual problems and prescribe any necessary lenses	Pediatric exam: $20 co-payment per visit Adult exam: $20 co-payment per visit	For services to treat a disease condition, please see your office visit benefit outlined above. Your plan does not cover contacts, frames or lenses.

How Your Pharmacy Coverage Works		
Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescription drugs require prior approval. To find a network pharmacy, please visit **www.bcbsvt.com/findadoctor.**		
Prescription Drugs (retail and home delivery)	**30-day/90-day**	**Limitations and important information**
Generic tier 1	Deductible, then 20% co-insurance	Prescription drug out-of-pocket limit: $1,350 for an individual plan per plan year/ $2,700 per two-person, parent and child(ren) or family plan per plan year. Your plan has an aggregate prescription drug out-of-pocket limit.
Generic tier 2	Deductible, then 20% co-insurance	
Preferred brand-name drug	Deductible, then 20% co-insurance	
Non-preferred brand name drug	Deductible, then 20% co-insurance	
Wellness Drugs		
	No cost to you	All generic and brand diabetic prescription drugs and diabetic supplies, when obtained through your prescription drug benefit, are covered at 100%.