

# 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% coinsurance 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 (Benefit Description and others, if applicable), log in to the Member Resource Center at [www.bluecrossvt.org/member-logins](http://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, coinsurance, or copayments 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](http://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](http://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 *
<b>Preventive Care</b> 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.	<b>Office visits:</b> \$25 copayment 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 <a href="http://www.bluecrossvt.org/preventive">www.bluecrossvt.org/preventive</a> .
<b>Office Visits</b> 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	<b>Primary care provider:</b> \$15 copayment per visit <b>Specialist:</b> \$25 copayment per visit <b>MH/SUD primary:</b> \$15 copayment per visit <b>MH/SUD specialist:</b> \$25 copayment per visit <b>Physical, speech, occupational therapy:</b> \$25 copayment per visit <b>Surgery:</b> No charge <b>Diagnostic services:</b> No charge <b>Injections other than immunizations and allergy shots:</b> No charge <b>Other treatments:</b> 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.
<b>Acupuncture</b>	Not covered	
<b>Ambulance Services</b> 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.	\$50 copayment 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.
<b>Chiropractic Care</b> Services to treat a neuromusculoskeletal condition	\$25 copayment per visit	You must use a network chiropractor. Requires prior approval after 12 visits per member, per plan year.
<b>Dental, Adult</b>	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.
<b>Dental, Pediatric</b>	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.

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Service or Supply	Your cost when you use network providers	Restrictions, limitations or other important information *
<b>Emergency Care</b> Hospital emergency room Emergency provider Mental health (MH) and substance use disorder (SUD) treatment	<b>Facility:</b> No charge <b>Provider:</b> No charge <b>MH/SUD facility:</b> No charge <b>MH/SUD provider:</b> 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.
<b>Home Care</b> Skilled nursing visits, short-term therapy, private duty nursing Infusion therapy Hospice	<b>Home health:</b> No charge <b>Hospice:</b> No charge <b>Physical, speech, occupational therapy:</b> 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
<b>Care in a Hospital</b> <b>Inpatient Care in a Hospital</b> Appropriate room and board accommodations All covered providers' services, including surgery Mental health (MH) and substance use disorder (SUD) treatment <b>Outpatient Care in a Hospital</b> 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	<b>Facility:</b> No charge <b>Provider:</b> No charge <b>MH/SUD inpatient:</b> No charge <b>Physical, speech, occupational therapy:</b> No charge <b>Outpatient provider:</b> No charge <b>Outpatient surgery facility:</b> No charge <b>Diagnostic services:</b> No charge <b>Advanced imaging:</b> No charge <b>MH/SUD outpatient primary:</b> \$15 copayment per visit <b>MH/SUD outpatient specialist:</b> \$25 copayment per visit <b>MH/SUD intensive outpatient:</b> 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 <a href="http://www.bluecrossvt.org/members/coverage#expandable-section-6195">www.bluecrossvt.org/members/coverage#expandable-section-6195</a>
<b>Medical Equipment and Supplies</b> Supplies and equipment that are primarily and customarily used only for a medical purpose.	\$100 Deductible, then 20% coinsurance	Hearing aids covered up to one per ear, every three years. Coverage includes evaluation, hearing aids, and batteries. You must see a hearing care professional within the hearing benefit network. Some medical equipment and supplies may require prior approval. Diabetic medication and supplies are not subject to deductible, coinsurance, or copayment.
<b>Nutritional Counseling</b>	\$25 copayment per visit	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 *
<b>OB-GYN Office Visits</b> Gynecological care	\$25 copayment per visit	
<b>Care During Pregnancy</b> Maternity care for mother and child	<b>Inpatient delivery:</b> No charge <b>Office visit:</b> \$25 copayment per visit	Other services and tests may take additional cost sharing. Members enrolled in our Better Beginnings program receive extra benefits.
<b>Rehabilitation and Skilled Nursing Facility Care</b> Inpatient treatment Outpatient cardiac or pulmonary rehabilitation	<b>Inpatient:</b> No charge <b>Cardiac:</b> No charge <b>Pulmonary:</b> 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.
<b>Telemedicine</b>	<b>Acute care:</b> \$15 copayment per visit <b>MH/SUD:</b> \$25 copayment per visit <b>Nutritional counseling:</b> \$25 copayment per visit <b>Lactation consultation:</b> Not covered	For telemedicine consultations with a provider, visit <a href="http://www.bluecrossvt.org/find-doctor/telemedicine-care">www.bluecrossvt.org/find-doctor/telemedicine-care</a> . For telemedicine consultations with a network provider, see service or supply in this document for payment terms and limitations.
<b>Transplant Care</b> Benefits for transplant related office visits, diagnostic services, surgeries and inpatient care	See Services 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.
<b>Urgent Care</b> Applies to urgent care facilities Includes provider and facility services	\$25 copayment 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.
<b>Vision Care</b> Routine exam to determine visual problems and prescribe any necessary lenses Coverage for prescription or fitting of eyeglasses or contact lenses	<b>Pediatric exam:</b> \$20 copayment per visit <b>Pediatric materials:</b> Not covered <b>Adult exam:</b> \$20 copayment per visit <b>Adult materials:</b> 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.

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## How Your Pharmacy Coverage Works

Some prescription drugs require prior approval. Visit [www.bluecrossvt.org](http://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	<b>Retail:</b> \$5 per 30-day supply; \$15 per 90-day supply <b>Home delivery pharmacy:</b> \$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	<b>Retail:</b> \$20 per 30-day supply; \$60 per 90 day supply <b>Home delivery pharmacy:</b> \$20 per 30-day supply; \$60 per 90-day supply	
Non-Preferred Brand Drugs	<b>Retail:</b> \$45 per 30-day supply; \$135 per 90-day supply <b>Home delivery pharmacy:</b> \$45 per 30-day supply; \$135 per 90-day supply	
Wellness Drugs	Wellness drugs process the same as any other prescription, as outlined above.	

\*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](http://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](https://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](https://bluecrossvt.org/privacypolicies).

## **NOTICE: Discrimination is Against the Law**

Blue Cross<sup>®</sup> and Blue Shield<sup>®</sup> 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](mailto: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](mailto: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). Sǎhṛab brikār ch̄wyh̄elūx đān phās'ā 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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