Vermont Blue advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

Vermont Blue Advantage Group PPO℠

Benefits-at-a-Glance Medical Services and Prescription Drugs

Vermont State Teachers' Retirement System PPO Medicare Advantage Plans

January 1, 2022 – December 31, 2022

The information provided is a summary of your benefits, showing what we cover and what you pay.
A complete list of services is found in the *Evidence of Coverage* and the *Medical Benefits Chart*.

If you have any questions about this plan's benefits, please call Vermont Blue Advantage Group PPO Customer Service (phone numbers are on the back cover of this booklet). A complete list of services is found in the *Evidence of Coverage which will be mailed to you* in your new member welcome kit and will be available online prior to your group's effective date at **www.VermontBlueAdvantage.com/VSTRS**.

Vermont Blue Advantage Group PPO has a network of doctors, hospitals, pharmacies, and other providers that participate with Medicare. You do not have to use our network providers, but all providers must participate with Medicare. For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at **www.VermontBlueAdvantage.com/VSTRS**.

To join Vermont Blue Advantage Group PPO, you must be enrolled in Medicare Part A and Medicare Part B and live in our service area of the United States and its territories.

Vermont Blue Advantage Group PPO

Vermont State Teachers' Retirement System PPO Medicare Advantage Plans

Cost-sharing Table	**JY** Medical & Prescription Drugs	**Comprehensive** Medical & Prescription Drugs	**VSTRS 65** Medical only
Premium	In addition to the Medicare Part B premium, you may also be required to pay a premium contribution as defined by your employer, union group, or third-party advisor. For premium contribution questions please contact the Vermont State Teachers' Retirement office toll-free at 1-800-642-3191, TTY users call 711, Monday through Friday 7:45 a.m.to 4:30 p.m. Eastern time.		
Medical Deductible *(Does not include prescription drugs)*	**In- and out-of-network combined:** $100 deductible applies to certain services as shown below	**In- and out-of-network combined:** $300 deductible applies to most services as shown below	**In- and out-of-network combined:** $0
Maximum Out-of-Pocket Responsibility *(Does not include prescription drugs)* All medical and hospital care services below apply to this annual amount, except for worldwide urgent care, emergency care, and emergency transportation.	**In- and out-of-network combined:** $600 annually	**In- and out-of-network combined:** $600 annually	Not applicable

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Ambulance Services Medically necessary transport: coverage applies to each one-way trip			
• Emergency ambulance in U.S. and its territories	20% coinsurance, after deductible, for emergency transport	20% coinsurance, after deductible, for emergency transport	$0 copay for emergency transport
• Non-emergency ambulance in U.S. and its territories	20% coinsurance, after deductible, for non-emergency transport	20% coinsurance, after deductible, for non-emergency transport	$0 copay for non-emergency transport
Chiropractic Care			
• Manual manipulation of the spine to correct subluxation	$20 copay for each Medicare-covered visit	20% coinsurance, after deductible, for each Medicare-covered visit	$0 copay for each Medicare-covered visit
• One routine office visit per year	$20 copay for each routine care visit	20% coinsurance, after deductible, for each routine care visit	$0 copay for each routine care visit
• One set of X-rays (up to 3 views) when performed by chiropractor	$0 copay for one annual set of X-rays	20% coinsurance, after deductible, for one annual set of X-rays	$0 copay for one annual set of X-rays
Diabetic Supplies			
• Diabetes supplies (e.g., monitoring)	$0 copay	$0 copay	$0 copay
• Diabetic shoes and inserts	$0 copay	$0 copay	$0 copay

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Doctor Visits • Primary Care Physician (PCP)	$20 copay	20% coinsurance, after deductible	$0 copay
• Specialists	$20 copay	20% coinsurance, after deductible	$0 copay
Durable Medical Equipment/ Supplies* • Durable medical equipment (e.g., wheelchairs, oxygen)	20% coinsurance, after deductible	20% coinsurance, after deductible	$0 copay
• Prosthetics (e.g., braces, artificial limbs)	20% coinsurance, after deductible	20% coinsurance, after deductible	$0 copay
Emergency Care In U.S. and its territories If you are admitted to the hospital within one day, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$20 copay	20% coinsurance, after deductible	$0 copay
Foot Care (podiatry services) Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	$20 copay	20% coinsurance, after deductible	$0 copay

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Hearing Services • Medicare-covered hearing exam to diagnose and treat hearing and balance issues	$0 copay	20% coinsurance, after deductible	$0 copay
Enhanced hearing services: • Routine hearing exam from NationsHearing, PCP or specialist once every year • Hearing aid fitting and evaluation	**In-network hearing services through NationsHearing:** $0 copay once per year **Out-of-network hearing services** $15 per primary care physician visit $40 per specialist visit		
• Hearing aid	**In-network through NationsHearing for hearing aids** Our plan pays up to a $1,250 allowance toward one new standard (analog or basic digital) hearing aid for each ear, once per year from a NationsHearing provider. Locate a NationsHearing provider at **www.NationsHearing.com/VBA** or call **1-877-246-6955**, 24 hours a day, 7 days a week. TTY users call **711**. **Out-of-network for hearing aid(s)** Not covered You are responsible for the difference between the plan's benefit allowance and the cost of the hearing aid(s).		
Home Health Agency Care Includes medically necessary intermittent skilled nursing care, home health aide services, rehabilitation services, etc. Referral required. Custodial care is not a benefit.	$0 copay	20% coinsurance, after deductible	$0 copay

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Home Infusion Therapy* • Home infusion drugs • Home infusion administration	$0 copay	20% coinsurance, after deductible	$0 copay
Inpatient Hospital Care* The copays are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row.	$0 copay Our plan covers an unlimited number of days for an inpatient hospital stay	20% coinsurance, after deductible Our plan covers an unlimited number of days for an inpatient hospital stay	$0 copay Our plan covers an unlimited number of days for an inpatient hospital stay
Medicare Part B Drugs* • COVID-19, flu, Hepatitis B, and Pneumococcal shots • Part B drugs, such as chemotherapy • Immunizations other than COVID-19, flu, Hepatitis B, and Pneumococcal shots • Other Part B drugs	$0 copay $0 copay	$0 copay 20% coinsurance, after deductible	$0 copay $0 copay

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Mental Health Outpatient Services • Outpatient therapy visit	$20 copay	20% coinsurance, after deductible	$0 copay
• Outpatient non-therapy visit	$20 copay	20% coinsurance, after deductible	$0 copay
Mental Health Inpatient Services Inpatient therapy visit If your hospital stay is longer than 90 days, our plan provides for up to 100 additional days of coverage, subject to the Medicare lifetime limit of 190 days. This limitation does not apply to inpatient psychiatric services furnished in a psychiatric unit of a general hospital. A benefit period starts the day you go into an inpatient psychiatric hospital. It ends when you go for 60 days in a row without inpatient psychiatric hospital care. No prior hospital stay is required. Copays, deducible and coinsurance restarts as new benefit period begins.	$0 copay	20% coinsurance, after deductible	$0 copay

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Online/Telehealth Visits Remote access technologies give you the opportunity to meet with your regular health care providers through electronic forms of communication (such as online). This does not replace an in-person visit but allows you to meet with your regular health care providers when it is not possible for you to meet with them in the office. When you can't get in to see your regular provider or need an appointment fast, you can also use Amwell Online Services site to access telehealth services by visiting **www.VermontBlueAdvantage.com/telehealth** or calling **1-855-635-1393.** TTY users call **711**.	$20 copay for your regular primary care physician and mental health provider via telehealth $20 copay for your regular specialist visits via telehealth $0 copay for urgent care, mental health, psychiatry, and nutrition counseling via Amwell	20% coinsurance, after deductible, for your regular primary care physician and mental health provider via telehealth 20% coinsurance, after deductible, for your regular specialist visits via telehealth $0 copay for urgent care, mental health, psychiatry, and nutrition counseling via Amwell	$0 copay for your regular primary care physician and mental health provider via telehealth $0 copay for your regular specialist visits via telehealth $0 copay for urgent care, mental health, psychiatry, and nutrition counseling via Amwell
Outpatient Diagnostic Tests and Therapeutic Services • X-rays • Low-tech diagnostic radiology services • High-tech diagnostic radiology services such as CT, MRI, MRA, and PET • Therapeutic radiology services • Lab services • Blood • Outpatient diagnostic procedures and tests	$0 copay	20% coinsurance, after deductible	$0 copay

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Outpatient Hospital Services* Ambulatory surgical and non-surgical services Outpatient hospital	$0 copay	20% coinsurance, after deductible	$0 copay
Outpatient Substance Abuse Individual or group therapy visit	$20 copay	20% coinsurance, after deductible	$0 copay
Physical Therapy Available in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities Limited to 30 visits per calendar year, including evaluations	$0 copay	20% coinsurance, after deductible	$0 copay

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Preventive Care Any additional preventive services approved by Medicare during the contract year will be covered.	$0 copay Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Annual physical exam • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, flexible sigmoidoscopy, guaiac-based fecal occult blood test, fecal immunochemical test, or DNA based colorectal screening) • Depression screening • Diabetes screening and diabetes self-management training • Glaucoma screening • Health and wellness education programs • HIV screening • Immunizations, including COVID-19, flu, Hepatitis B, and Pneumococcal shots • Intensive behavioral therapy for obesity • Medical nutrition therapy services • Medicare Diabetes Prevention Program • Prostate cancer screenings • Screening and intensive behavioral therapy for obesity • Screening for lung cancer with low dose computed tomography • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Tobacco use cessation counseling (for people with no sign of tobacco-related disease) • “Welcome to Medicare” preventive visit (one-time)		

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Rehabilitation Services • Cardiac rehabilitation/intensive cardiac services • Pulmonary rehabilitation • Occupational therapy visit: Limited to 30 visits per calendar year, including evaluations • Speech and language therapy: Limited to 30 visits per calendar year, including evaluations	$0 copay	20% coinsurance, after deductible	$0 copay
Renal Dialysis Services for Kidney Disease Home health care visits, equipment, dialysis, and supplies	$0 copay	20% coinsurance, after deductible	$0 copay
Skilled Nursing Facility (SNF) • Days 1-99 • Day 100 and above*	$0 copay $0 copay	20% coinsurance, after deductible 20% coinsurance, after deductible	$0 copay You pay all costs.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met	$0 copay	20% coinsurance, after deductible	$0 copay

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Urgently Needed Services In U.S. and its territories	$20 copay	20% coinsurance, after deductible	$0 copay
You can use Amwell Online Visits to access telehealth services by visiting **www.VermontBlueAdvantage.com/telehealth** or calling **1-855-635-1393**. TTY users call **711.**	$0 copay for urgent care online telehealth visit	$0 copay for urgent care online telehealth visit	$0 copay for urgent care online telehealth visit

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Vision Services Original Medicare covers limited vision services, including:			
• Exam to diagnose and treat diseases and conditions of the eye	$0 copay	$0 copay	$0 copay
• Eyeglasses or contact lenses, after cataract surgery	$0 copay	20% coinsurance, after deductible	$0 copay
• Diabetic retinopathy screening	$0 copay	$0 copay	$0 copay
We offer additional enhanced vision benefits not covered by Original Medicare, including: • Enhanced (non-Medicare covered) supplemental routine eye exam through a VSP Choice Network provider or out-of-network provider	$0 copay every 12 months	$0 copay every 12 months	$0 copay every 12 months
• Enhanced vision benefit has an allowance toward elective contact lenses, frames or complete glasses (lenses and frames) through a VSP Choice Network provider	$200 allowance every 12 months	$200 allowance every 12 months	$200 allowance every 12 months
To locate a VSP Choice Network provider, call **1-855-492-9028** from 8 a.m. to 8 p.m. seven days a week. TTY users call **1-800-428-4833**. You can also visit **www.vsp.com**.			

Cost-sharing Table	JY Medical & Prescription Drugs Out-of-network	Comprehensive Medical & Prescription Drugs Out-of-network	VSTRS 65 Medical only Out-of-network
Worldwide Emergency Coverage If you need care when you're outside of the United States, you have coverage for emergency medical care, emergency transportation, and urgent care only.	There is a combined $50,000 lifetime plan coverage limit for emergency and urgent care services outside the U.S. and its territories.		
• Worldwide emergency medical care	$0 copay	$0 copay	$100 copay
• Worldwide emergency transportation (ambulance)	$0 copay	$0 copay	$100 copay
• Worldwide urgent care	$0 copay	$0 copay	$50 copay

Additional Benefits	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Contraceptive Devices	$0 copay	20% coinsurance, after deductible	$0 copay
Gradient Compression Stockings	20% coinsurance, after deductible	20% coinsurance, after deductible	$0 copay
Private Duty Nursing	20% coinsurance, after deductible, with an annual coverage limit of 14 hours	20% coinsurance, after deductible, with an annual coverage limit of 14 hours	Not a covered benefit
Weight Loss Surgery*	$0 copay	20% coinsurance, after deductible	$0 copay
Wigs, Wig Stand, Adhesive* Wigs must be prescribed by a physician and medically necessary.	20% coinsurance, after deductible	20% coinsurance, after deductible	$0 copay

Prescription Benefits				
Stage 1: Deductible	**JY and Comprehensive:** Because there is no deductible for the plan, this payment stage does not apply to you. **VSTRS 65:** Prescription drugs are not a covered benefit.			
Stage 2: Initial Coverage **JY and Comprehensive:** You pay the following until your out-of-pocket costs reach $600. See Chapter 6 of the *Evidence of Coverage* for information on how Medicare counts your out-of-pocket costs. **VSTRS 65:** Prescription drugs are not a covered benefit.				
Tiers (includes specialty drugs limited to a 30-day supply)	**Retail network pharmacy** **30-day supply**	**Mail-order network pharmacy** **30-day supply**	**Retail network pharmacy** **90-day supply**	**Mail-order network pharmacy** **90-day supply**
Tier 1: Generic	**JY:** $5 **Comprehensive:** $5	**JY:** $5 **Comprehensive:** $5	**JY:** $15 **Comprehensive:** $15	**JY:** $10 **Comprehensive:** $10
Tier 2: Preferred Brand	**JY:** $20 **Comprehensive:** $20	**JY:** $20 **Comprehensive:** $20	**JY:** $60 **Comprehensive:** $60	**JY:** $40 **Comprehensive:** $40
Tier 3: Non-Preferred Drug	**JY:** $45 **Comprehensive:** $45	**JY:** $45 **Comprehensive:** $45	**JY:** $135 **Comprehensive:** $135	**JY:** $90 **Comprehensive:** $90
Stage 3 and 4: Coverage Gap & Catastrophic Stages: Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.				
Stage 3: Coverage Gap	**JY and Comprehensive:** This stage doesn't apply. You continue to pay your Stage 2 copay amounts until you reach Catastrophic Coverage. **VSTRS 65:** Prescription drugs are not a covered benefit.			
Stage 4: Catastrophic Coverage	**JY and Comprehensive:** $3.95 generic/$9.85 brand. **VSTRS 65:** Prescription drugs are not a covered benefit.			

For more information on the phases of the benefit, please call us or access our *Evidence of Coverage* online at **www.VermontBlueAdvantage.com/VSTRS**.

If your plan includes prescription benefits, your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations. Youcan see the most complete and current information about which drugs are covered on our website (**www.VermontBlueAdvantage.com/VSTRS**).

If your plan includes prescription benefits, your plan also covers additional non-Medicare covered medications not listed in your drug formulary.

If your plan includes prescription benefits, youmust generally use network pharmacies to fill your prescriptions for covered Part D drugs. Youcan see our plan's pharmacy directory at our website (**www.VermontBlueAdvantage.com/VSTRS**). Costs may differ based on pharmacy type.

See our plan's provider directory at our website **www.VermontBlueAdvantage.com/VSTRS** or call us and we will send you a copy of the provider directory.

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For more information

A complete list of services is found in the *Evidence of Coverage* which will be mailed to you in your new member welcome kit and will be available online prior to your group's effective date at **www.VermontBlueAdvantage.com/VSTRS**.

If you are not yet enrolled in the Vermont Blue Advantage plan call the transitional call center toll-free **1-800-344-6690,** Monday through Friday, 7 a.m. to 4:30 p.m. Eastern time. TTY users should call **1-800-535-2227**.

Once you are enrolled, call toll-free **1-800-572-0280,** Monday through Friday, 8 a.m. to 8 p.m. Eastern time, with weekend hours October 1 to March 31. TTY users should call **711**.

This document is available in other formats such as audio CD and large print. This document may be available in a non-English language. For additional information, call us at **1-800-572-0280**. TTY users should call **711**.

To learn more about Original Medicare, you can order a copy of the "Medicare & You" handbook at www.medicare.gov, or you can call Medicare at **1-800-MEDICARE** (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Out-of-network/non- contracted providers are under no obligation to treat Vermont Blue Advantage Group PPO members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.