STATE OF VERMONT EMPLOYEE MEDICAL PLAN OPTIONS FOR
ACTIVE AND RETIRED MEMBERS

Benefit/Feature	SelectCare POS Plan		TotalChoice Plan
	In-Network	**Out-of-Network**	
Annual DEDUCTIBLE	none	$500 per person; $1,000 per family	$300 per person; $600 per family
MAXIMUM annual COPAYS (after deductible is met)	$1,500 per person; $3,000 per family	$1,500 per person; $3,000 per family	$750 per person; $2,250 per family
Maximum Lifetime Benefit Per Member	none	none	none
PERCENTAGE THAT THE PLAN PAYS			
Inpatient Hospital	100% after $250 co-pay	70%	90%
Outpatient Hospital	100%	70%	80%
Emergency Room	100% after $75 co-pay (waived if admitted)	70%	80%
Physician Charges Office Visit Specialist Visit MRI In-Hospital Visit Surgery	 100% after $25 copay 100% after $30 copay 100% after $30 copay 100% 100%	70%	80% 90% inpatient; 80% outpatient 90%
Diagnostic X-ray and Labs	100%	70%	80%
Home Healthcare	100%	70%	80%
COMMON BENEFITS IN ALL PLAN OPTIONS			
Preventive Exams & Tests- Program Benefits	Covered at 100%.		
Wellness Program Benefits	Available to all active employees and retirees in any of the health plan options, at no charge to the employee or retiree		
COMMON BENEFITS IN ALL PLAN OPTIONS EXCEPT THE SAFETYNET PLAN			
Mental Health & Sustance Abuse Program Benefits	In-Network: Paid at 100%. Out-of-Network: Deductibles & copay required.		
Prescription Drugs • **Retail** • **Mail**	This prescription drug card plan combines both local retail and mail order drugs. Annual deductible of $50 per person/$150 family. Individual pays 10% copay/generic drugs, 20% copay/preferred brand drugs, and 40% copay/non-preferred brand drugs. For both mail order and retail, the maximum annual out-of-pocket, including deductible, is $800 per covered member for generic drugs and preferred brands, and $1,350 for non-preferred brand drugs. Total annual out of pocket will not exceed $1,350/ person, $2,700/family.		
Routine Vision Care	The plan pays $100 every two years, with no deductible, coinsurance, or copay. Benefits available for every plan member, **including dependents.** Covers routine exams and/or lens changes if the prescription changed. Doesn't include replacement lens if lost/damaged.		