



**BlueCross BlueShield  
of Vermont**

*Independent Licensees of the Blue Cross and Blue Shield Association.*



**BlueCare Access HMO \$20 PCP co-payment, \$30 Specialist co-payment, \$150 Emergency Care, \$50 Ambulance, \$1,500 Inpatient Deductible and \$750 Outpatient Deductible**

**Prescription Drugs - \$100 Deductible, \$5 Generic Co-payment, 40% Preferred Brand-Name Coinsurance, or 60% Non-Preferred Brand-Name Coinsurance**

**Created For: BRS**

BENEFIT HIGHLIGHTS	NETWORK PROVIDERS
<b>Network</b> <i>Members who reside in the BlueCare Service Area (i.e. Vermont and the following New Hampshire bordering counties: Coos, Grafton, Cheshire and Sullivan) must use TVHP providers. Members who reside outside of the BlueCare Service Area must use any BlueCard Preferred Provider.</i>	Please visit the following website to find a doctor: <a href="http://www.bcbsvt.com/FindaDoctor">www.bcbsvt.com/FindaDoctor</a> Then select "BlueCare Access"
<b>Out-of-Area Eligible Dependents</b> <i>You must complete the "Dependent Out-of-Service Area Coverage Request Form". BlueCard Preferred Provider Network must be used.</i>	Please visit the following website to find a doctor: <a href="http://www.bcbsvt.com/FindaDoctor">www.bcbsvt.com/FindaDoctor</a> Then select "BlueCare Access"
<b>Prior Approvals</b> <i>All medical management rules apply.</i>	If you live inside of the BlueCare Service Area, Network Providers will take care of prior approvals for you. If you live outside of the BlueCare Service Area, it is your responsibility to know when you must request prior approval and to make sure your Physician submits a prior approval request. Please visit the following website for a list of Drugs and services that require prior approval: <a href="http://www.bcbsvt.com/priorapproval">www.bcbsvt.com/priorapproval</a>
<b>Lifetime Maximum</b> <i>Includes medical and prescription services</i>	Unlimited
<b>Transplant Services Benefit Maximum</b>	\$2,000,000

OUTPATIENT CARE	NETWORK PROVIDERS	
	YOU PAY	PLAN PAYS
<b>Adult Preventive Office Visit</b> <i>Excludes diagnostic services such as laboratory and x-ray</i>	No member cost	100% of our allowed price
<b>Gynecological Preventive Office Visit</b> <i>Exclude diagnostic services</i>	No member cost	100% of our allowed price
<b>Well Baby and Child Office Visits</b> <i>Includes routine immunizations</i>	No member cost	100% of our allowed price
<b>Screening Mammogram</b> <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price
<b>Colorectal Screening</b> <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price
<b>Maternity Office Visits</b> <i>One co-payment covers all maternity office visits</i>	\$20 co-payment	100% of our allowed price after co-payment
<b>Office Visits with Primary Care Physician</b>	\$20 co-payment	100% of our allowed price after co-payment
<b>Office Visits with Specialist</b>	\$30 co-payment	100% of our allowed price after co-payment



OUTPATIENT CARE	YOU PAY	PLAN PAYS
<b>Mental Health and Substance Abuse Office Visits</b> <i>Requires prior approval</i>	\$30 co-payment	100% of our allowed price after co-payment
<b>Nutritional Counseling</b> <i>Up to three visits; visits for treatment of diabetes do not count toward the three visit limit.</i>	\$30 co-payment	100% of our allowed price after co-payment
<b>Chiropractic Visits</b> <i>Prior approval required after 12 visits</i>	\$30 co-payment	100% of our allowed price after co-payment
<b>Outpatient Physical, Occupational, and Speech Therapy</b> <i>Up to 30 visits combined per calendar year</i>	\$30 co-payment	100% of our allowed price after co-payment
<b>Diagnostic Services</b> <i>Includes laboratory and x-rays</i>	No member cost	100% of our allowed price
<b>Emergency Care</b> <i>Includes emergency room and physician services, covered when your condition meets criteria for necessary emergency care</i>	\$150 co-payment (co-payment waived if admitted to the hospital).	100% of our allowed price after co-payment
<b>Outpatient Surgery</b> <i>Prior approval may be required</i>	\$750 deductible	100% of our allowed price after deductible
INPATIENT CARE	YOU PAY	PLAN PAYS
<b>Inpatient Care, General Hospital</b> <i>Requires pre-certification</i>	\$1,500 deductible	100% of our allowed price after deductible
<b>Inpatient Care, Mental Health or Substance Abuse</b> <i>Requires prior approval</i>	\$1,500 deductible	100% of our allowed price after deductible
HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS
<b>Inpatient Skilled Nursing</b>	\$1,500 deductible	100% of our allowed price after deductible
<b>Inpatient Rehabilitation</b> <i>Required prior approval</i>	\$1,500 deductible	100% of our allowed price after deductible
<b>Cardiac Rehabilitation</b> <i>Up to 36 sessions per acute cardiac event; requires prior approval</i>	No member cost	100% of our allowed price
<b>Home Health Care</b>	\$30 co-payment	100% of our allowed price after co-payment
<b>Hospice Care</b>	No member cost	100% of our allowed price
<b>Private Duty Nursing</b> <i>Up to \$2,000 per member per calendar year; requires prior approval</i>	\$30 co-payment	100% of our allowed price after co-payment
OTHER SERVICES	YOU PAY	PLAN PAYS
<b>Ambulance</b> <i>Includes emergency and routine transport; prior approval required for non-emergency transport</i>	\$50 co-payment	100% of our allowed price after co-payment
<b>Medical Equipment and Supplies</b> <i>Prior approval may be required</i>	20% of our allowed price	80% of our allowed price



PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS
<b>Retail Pharmacy Program</b> <i>Up to a 30-day supply. Prior approval may be required</i>	\$100 deductible then	After \$100 deductible and co-payment or coinsurance
	\$5 generic co-payment	100% after co-payment
	40% preferred brand-name coinsurance	60% preferred brand-name coinsurance
	60% non-preferred brand-name coinsurance	40% non-preferred brand-name coinsurance
<b>Mail Order Pharmacy Program</b> <i>Up to a 90-day supply. Prior approval may be required</i>	\$100 deductible then	After \$100 deductible and co-payment or coinsurance
	\$10 generic co-payment	100% after co-payment
	40% preferred brand-name coinsurance	60% preferred brand-name coinsurance
	60% non-preferred brand-name coinsurance	40% non-preferred brand-name coinsurance

*Diabetic medications are covered like any other medication*

*DME: up to \$25,000 per member per year maximum. Prosthetics and Diabetic Supplies are not included in maximum*

*Deductible will accumulate January 1 through December 31 with no carry-over to the following year.*

*Benefit Exclusion Rider*

*This document summarizes the benefits of your health care plan per calendar year. Your subscriber contract defines the complete terms and conditions of your benefits in detail. Should any questions arise concerning your benefits, your subscriber contract governs.*

*For plans that have a deductible or co-payment for inpatient and outpatient hospital services, there is a limit of two deductibles or co-payments per family per year.*