



**BlueCross BlueShield
of Vermont**

Independent Licensees of the Blue Cross and Blue Shield Association.



BlueCare HMO

**\$20 PCP Co-payment, \$30 Specialist Co-payment, \$100 Emergency Care, \$50 Ambulance,
Combined \$1,000 Inpatient / Outpatient Deductible**

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

Created For: Business Resource Services (BRS)

BENEFIT HIGHLIGHTS	NETWORK PROVIDERS
Lifetime Maximum <i>Includes medical and prescription drug benefits</i>	Unlimited
Transplant Services Benefit Maximum	\$2,000,000

	NETWORK PROVIDERS	
OUTPATIENT CARE	YOU PAY	PLAN PAYS
Adult Preventive Office Visits <i>Excludes diagnostic services such as laboratory and x-ray</i>	No member cost	100% of our allowed price
Gynecological Preventive Office Visits <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price
Well Baby and Child Office Visits <i>Includes routine immunizations</i>	No member cost	100% of our allowed price
Screening Mammogram <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price
Colorectal Screening <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price
Maternity Office Visits <i>One co-payment covers all maternity office visits</i>	\$20 co-payment	100% after co-payment
Office Visits with Primary Care Physician	\$20 co-payment	100% after co-payment
Office Visits with Specialist	\$30 co-payment	100% after co-payment
Mental Health and Substance Abuse Office Visits	\$30 co-payment	100% after co-payment
Nutritional Counseling <i>Up to three visits; visits for treatment of diabetes do not count toward the three-visit limit</i>	\$30 co-payment	100% after co-payment
Chiropractic Visits <i>Prior approval is required after 12 visits</i>	\$30 co-payment	100% after co-payment
Outpatient Physical, Occupational, and Speech Therapy <i>Up to 30 visits combined per calendar year</i>	\$30 co-payment	100% after co-payment
Diagnostic Services <i>Includes laboratory and x-ray</i>	No Member Cost	100% of our allowed price
Emergency Care <i>Includes emergency room and physician services, covered when your condition meets criteria for necessary emergency care</i>	\$100 co-payment (co-payment waived if admitted as an inpatient)	100% of our allowed price after co-payment
Outpatient Surgery <i>Prior approval may be required. Outpatient and inpatient deductibles are combined</i>	\$1,000 deductible	100% of our allowed price after deductible



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INPATIENT CARE	YOU PAY	PLAN PAYS
Inpatient Care, General Hospital <i>Requires precertification. Outpatient and inpatient deductibles are combined</i>	\$1,000 deductible	100% of our allowed price after deductible
Inpatient Care, Mental Health or Substance Abuse <i>Requires prior approval. Outpatient and inpatient deductibles are combined</i>	\$1,000 deductible	100% of our allowed price after deductible
HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS
Inpatient Skilled Nursing <i>Outpatient and inpatient deductibles are combined</i>	\$1,000 deductible	100% of our allowed price after deductible
Inpatient Rehabilitation <i>Requires prior approval. Outpatient and inpatient deductibles are combined</i>	\$1,000 deductible	100% of our allowed price after deductible
Cardiac Rehabilitation <i>Up to 36 sessions per acute cardiac event; requires prior approval</i>	No Member Cost	100% of our allowed price
Home Health Care	\$30 co-payment	100% of our allowed price after co-payment
Hospice Care	No Member Cost	100% of our allowed price
Private Duty Nursing <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
Ambulance <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
Medical Equipment and Supplies <i>Prior approval may be required</i>	20% of our allowed price	80% of our allowed price

PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS
Retail Pharmacy Program <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
Mail Order Pharmacy Program <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.



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For plans that include an inpatient and outpatient deductible, the deductibles are limited to two deductibles per family per year