



**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 then \$5 Generic, \$25 Preferred Brand-Name, or \$50 Non-Preferred Brand-Name Co-payments

Created For: BRS Grandfathered no vision

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

| OUTPATIENT CARE | NETWORK PROVIDERS | |
|---|---|--|
| | 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 | |
| | \$5 generic co-payment | 100% after co-payment |
| | \$25 preferred brand-name co-payment | 100% after co-payment |
| | \$50 non-preferred brand-name co-payment | 100% after co-payment |
| Mail Order Pharmacy Program <i>Up to a 90-day supply. Prior approval may be required</i> | \$100 deductible then | |
| | \$10 generic co-payment | 100% after co-payment |
| | \$50 preferred brand-name co-payment | 100% after co-payment |
| | \$100 non-preferred brand-name co-payment | 100% after co-payment |

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