



**BlueCross BlueShield
of Vermont**

Independent Licensees of the Blue Cross and Blue Shield Association.



BlueCare Options - Open Access Plus (POS)

Preferred Benefits: \$30 Office Visit Co-payment, \$3,000 Individual Deductible, 20% Coinsurance

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

Created For: BRS POS without vision

BENEFIT HIGHLIGHTS	PREFERRED	STANDARD
Calendar Year Deductible	\$3,000 Individual \$6,000 Family	\$5,000 Individual \$10,000 Family
Coinsurance	Plan pays 80% of our allowed price after you meet your deductible. You pay 20% of our allowed price up to your out-of-pocket limit.	Plan pays 60% of our allowed price after you meet your deductible. You pay 40% of our allowed price up to your out-of-pocket limit.
Calendar Year Out-of-Pocket Limit	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family
Lifetime Maximum <i>Includes medical and prescription drug benefits</i>	Unlimited	\$2,000,000 per member per lifetime
Transplant Services Benefit Maximum	\$2,000,000 per member per lifetime	\$2,000,000 per member per lifetime

OUTPATIENT CARE	PREFERRED		STANDARD	
	YOU PAY	PLAN PAYS	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	40% of our allowed price after deductible	60% of our allowed price after deductible
Gynecological Preventive Office Visits <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price	40% of our allowed price after deductible	60% of our allowed price after deductible
Well Baby and Child Office Visits <i>Includes routine immunizations</i>	No member cost	100% of our allowed price	40% of our allowed price after deductible	60% of our allowed price after deductible
Screening Mammogram <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price	No member cost	100% our allowed price
Colorectal Screening <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price	40% of our allowed price after deductible	60% of our allowed price after deductible
Maternity Office Visits <i>Prior approval required when you use a non-network provider; one preferred co-payment covers all maternity office visits</i>	\$30 co-payment	100% of our allowed price after co-payment	40% of our allowed price after deductible	60% of our allowed price after deductible
Primary Care Physician Office Visits	\$30 co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit
Mental Health and Substance Abuse Office Visits <i>Requires prior approval</i>	\$30 co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit
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% of our allowed price after co-payment	100% of charges	Not a covered benefit
Chiropractic Visits <i>Prior approval required after 12 visits</i>	\$30 co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit



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Diagnostic Services <i>Includes laboratory and x-ray</i>	20% of our allowed price after deductible	80% of our allowed price after deductible	40% of our allowed price after deductible	60% of our allowed price after deductible
Emergency Care <i>Covered as preferred benefits when your condition meets criteria for necessary emergency care</i>	\$100 co-payment	100% of our allowed price after co-payment	No standard benefits	No standard benefits
Outpatient Surgery <i>Prior approval may be required</i>	20% of our allowed price after deductible	80% of our allowed price after deductible	40% of our allowed price after deductible	60% of our allowed price after deductible
Outpatient Physical, Occupational, and Speech Therapy <i>Up to 30 visits combined per calendar year</i>	\$30 co-payment	100% of our allowed price after co-payment	40% of our allowed price after deductible	60% of our allowed price after deductible
INPATIENT CARE	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Inpatient Care, General Hospital Admission <i>Requires precertification</i>	20% of our allowed price after deductible	80% of our allowed price after deductible	40% of our allowed price after deductible	60% of our allowed price after deductible
Maternity and newborn care <i>Newborns must be enrolled within 31 days</i>	20% of our allowed price after deductible	80% of our allowed price after deductible	40% of our allowed price after deductible	60% of our allowed price after deductible
Inpatient Care, Mental Health or Substance Abuse Admission <i>Requires prior approval</i>	20% of our allowed price after deductible	80% of our allowed price after deductible	100% of charges	Not a covered benefit
HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Inpatient Skilled Nursing	20% of our allowed price after deductible	80% of our allowed price after deductible	40% of our allowed price after deductible	60% of our allowed price after deductible
Inpatient Rehabilitation Services <i>Rehabilitation requires prior approval</i>	20% of our allowed price after deductible	80% of our allowed price after deductible	100% of charges	Not a covered benefit
Hospice Care Services	20% of our allowed price after deductible	80% of our allowed price after deductible	40% of our allowed price after deductible	60% of our allowed price after deductible
Cardiac Rehabilitation <i>Up to 36 sessions per acute cardiac event; requires prior approval</i>	20% of our allowed price after deductible	80% of our allowed price after deductible	100% of charges	Not a covered benefit
Home Health Care	\$30 co-payment	100% of our allowed price after co-payment	40% of our allowed price after deductible	60% of our allowed price after deductible
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	40% of our allowed price after deductible	60% of our allowed price after deductible
OTHER SERVICES	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Ambulance <i>Includes emergency and routine transport; prior approval required for non-emergency transport; covered as preferred benefits when your condition meets criteria for necessary emergency care</i>	20% of our allowed price after deductible	80% of our allowed price after deductible	No standard benefits	No standard benefits
Medical Equipment and Supplies <i>Prior approval may be required</i>	20% of our allowed price after deductible	80% of our allowed price after deductible	100% of charges	Not a covered benefit



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PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS	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	100% of charges	Not a covered benefit
	\$5 generic co-payment	100% after co-payment	100% of charges	Not a covered benefit
	40% preferred brand-name coinsurance	60% preferred brand-name coinsurance	100% of charges	Not a covered benefit
	60% non-preferred brand-name coinsurance	40% non-preferred brand-name coinsurance	100% of charges	Not a covered benefit
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	100% of charges	Not a covered benefit
	\$10 generic co-payment	100% after co-payment	100% of charges	Not a covered benefit
	40% preferred brand-name coinsurance	60% preferred brand-name coinsurance	100% of charges	Not a covered benefit
	60% non-preferred brand-name coinsurance	40% non-preferred brand-name coinsurance	100% of charges	Not a covered benefit

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.

Benefits paid by your health plan for services rendered by Preferred Providers and Non-Preferred Providers are combined and applied to a common lifetime Transplant Services Benefit Maximum dollar amount.