



BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

HSA Blue - High Deductible Health Plan

\$4,000 / \$8,000 Individual / Family Deductible, 20% Coinsurance

Created For: BRS

BENEFIT HIGHLIGHTS	ALL PROVIDERS
Calendar Year Deductible <i>Includes medical and prescription drug benefits. If you have a two-person or family membership, the entire deductible must be met by any combination of family members before benefits are paid by the plan.</i>	\$4,000 Individual \$8,000 Two-Person and Family
Coinsurance	Plan pays 80% of allowed price after deductible is met.
Calendar Year Out-of-Pocket Limit	\$5,000 Individual \$10,000 Two-Person and Family
Lifetime Maximum <i>Includes medical and prescription drug benefits; excludes transplant services</i>	\$2,000,000 per member per lifetime
Transplant Services Benefit Maximum	\$2,000,000 per member per lifetime

OUTPATIENT CARE	ALL 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
Well Baby and Child Office Visits <i>Includes routine immunizations</i>	No member cost	100% of our allowed price
Screening Mammogram and PAP Test <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	Deductible, then 20% of allowed price	80% coinsurance after deductible
Other Physician Office Visits	Deductible, then 20% of allowed price	80% coinsurance after deductible
Mental Health and Substance Abuse Office Visits <i>Requires prior approval</i>	Deductible, then 20% of allowed price	80% coinsurance after deductible
Nutritional Counseling <i>Up to three visits; visits for treatment of diabetes do not count toward the three-visit limit</i>	Deductible, then 20% of allowed price	80% coinsurance after deductible
Chiropractic Visits <i>Prior approval required after 12 visits</i>	Deductible, then 20% of allowed price	80% coinsurance after deductible
Diagnostic Services <i>Includes laboratory and x-ray</i>	Deductible, then 20% of allowed price	80% coinsurance after deductible
Emergency Care <i>Includes emergency room and physician services, covered when your condition meets criteria for necessary emergency care</i>	Deductible, then 20% of allowed price	80% coinsurance after deductible
Outpatient Surgery <i>Prior approval may be required</i>	Deductible, then 20% of allowed price	80% coinsurance after deductible



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OUTPATIENT CARE	YOU PAY	PLAN PAYS
Outpatient Physical, Occupational, and Speech Therapy <i>Up to 30 visits combined per calendar year</i>	Deductible, then 20% of allowed price	80% coinsurance after deductible
INPATIENT CARE	YOU PAY	PLAN PAYS
Inpatient Care, General Hospital Admission, Mental Health or Substance Abuse Admission <i>Prior approval required for all mental health and substance abuse treatment. Pre-certification is required for inpatient services.</i>	Deductible, then 20% of allowed price	80% coinsurance after deductible
HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS
Inpatient Skilled Nursing	Deductible, then 20% of allowed price	80% coinsurance after deductible
Inpatient Rehabilitation <i>Requires prior approval</i>	Deductible, then 20% of allowed price	80% coinsurance after deductible
Cardiac Rehabilitation <i>Up to 36 sessions per acute cardiac event; requires prior approval</i>	Deductible, then 20% of allowed price	80% coinsurance after deductible
Home Health and Hospice Care Services	Deductible, then 20% of allowed price	80% coinsurance after deductible
Private Duty Nursing <i>Up to \$2,000 per member per calendar year; requires prior approval</i>	Deductible, then 20% of allowed price	80% coinsurance after deductible
OTHER SERVICES	YOU PAY	PLAN PAYS
Ambulance <i>Includes emergency and routine transport. Prior approval required for non-emergency transport.</i>	Deductible, then 20% of allowed price	80% coinsurance after deductible
Medical Equipment and Supplies <i>Prior approval may be required</i>	Deductible, then 20% of allowed price	80% coinsurance after deductible

PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS
Retail Pharmacy Program <i>Up to a 30-day supply. Prior approval may be required</i>	Deductible, then 20% of allowed price	80% after deductible; 100% after out-of-pocket limit
Mail Order Pharmacy Program <i>Up to a 90-day supply. Prior approval may be required</i>	Deductible, then 20% of allowed price	80% after deductible; 100% after out-of-pocket limit

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.