



**BlueCross BlueShield  
of Vermont**

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



## HSA BlueCare - High Deductible Health Plan

**\$3,000 / \$6,000 Individual / Family Deductible, 0% Coinsurance**

**Created For: BRS**

BENEFIT HIGHLIGHTS	NETWORK PROVIDERS
<b>Calendar Year Deductible</b> <i>Includes medical and prescription drug benefits. Plan pays benefits for an individual after he or she has met the individual deductible</i>	\$3,000 Individual \$6,000 Two-Person and Family
<b>Coinsurance</b>	Plan pays 100% of allowed price after deductible is met
<b>Lifetime Maximum</b> <i>Includes medical and prescription drug benefits; excludes transplant services</i>	Unlimited
<b>Transplant Services Benefit Maximum</b>	\$2,000,000 per member per lifetime

OUTPATIENT CARE	NETWORK PROVIDERS	
	YOU PAY	PLAN PAYS
<b>Adult Preventive Office Visits</b> <i>Excludes diagnostic services such as laboratory and x-ray</i>	No member cost	100% of our allowed price
<b>Gynecological Preventive Office Visits</b> <i>Excludes 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 and PAP Test</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>Prior approval required when you use non-network providers.</i>	Deductible, then No member cost	100% after deductible
<b>Primary Care Physician Office Visits</b>	Deductible, then No member cost	100% after deductible
<b>Other Specialist Office Visits</b>	Deductible, then No member cost	100% after deductible
<b>Mental Health and Substance Abuse Office Visits</b> <i>Requires prior approval</i>	Deductible, then No member cost	100% after deductible
<b>Chiropractic Visits</b> <i>Prior approval required after 12 visit.</i>	Deductible, then No member cost	100% after deductible
<b>Diagnostic Services</b> <i>Includes Laboratory and X-rays.</i>	Deductible, then No member cost	100% after deductible
<b>Emergency Care</b> <i>Includes physician and facility services. Covered when your condition meets criteria for necessary emergency care</i>	Deductible, then No member cost	100% after deductible
<b>Outpatient Surgery</b> <i>Prior approval may be required</i>	Deductible, then No member cost	100% after deductible



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OUTPATIENT CARE	YOU PAY	PLAN PAYS
<b>Outpatient Physical, Occupational, and Speech Therapy</b> <i>Up to 30 visits combined per calendar year.</i>	Deductible, then No member cost	100% after deductible
INPATIENT CARE	YOU PAY	PLAN PAYS
<b>Inpatient Stay (semi-private room or intensive care), includes Mental Health and Substance Abuse care</b> <i>Prior approval required for all mental health and substance abuse treatment. Pre-certification is required for inpatient services.</i>	Deductible, then No member cost	100% after deductible
HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS
<b>Inpatient Skilled Nursing or Rehabilitation</b> <i>Prior approval required for rehabilitation</i>	Deductible, then No member cost	100% after deductible
<b>Home Health and Hospice Care Services</b>	Deductible, then No member cost	100% after deductible
<b>Cardiac Rehabilitation</b> <i>Up to 36 sessions per acute cardiac event; requires prior approval</i>	Deductible, then No member cost	100% after deductible
<b>Private Duty Nursing</b> <i>Up to \$2,000 per member per calendar year. Prior approval is required</i>	Deductible, then No member cost	100% after deductible
OTHER SERVICES	YOU PAY	PLAN PAYS
<b>Ambulance</b> <i>Includes emergency and routine transport. Prior approval required for non-emergency transport.</i>	Deductible, then No member cost	100% after deductible
<b>Medical Equipment and Supplies</b> <i>Prior approval may be required</i>	Deductible, then No member cost	100% after deductible

PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS
<b>Retail Pharmacy Program</b> <i>Up to a 30-day supply. Prior approval may be required</i>	Deductible, then no member cost	100% after deductible
<b>Mail Order Pharmacy Program</b> <i>Up to a 90-day supply. Prior approval may be required</i>	Deductible, then no member cost	100% after deductible

*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.*