BlueCross BlueShield of Vermont
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The Vermont Health Plan

BlueCare Access HMO

$20 PCP Co-payment, $30 Specialist Co-payment, $250 Emergency Care Co-payment, $50 Ambulance Co-payment, $1,500 Inpatient Deductible and $750 Outpatient Deductible
PPACA Compliant
Prescription Drugs - $100 Deductible, $5 Generic Co-payment, 40% Preferred Brand-Name Member Coinsurance, or 60% Non-Preferred Brand-Name Member Coinsurance
Vision Exam $20 co-payment

Created For: Business Resource Services

BENEFIT HIGHLIGHTS	NETWORK PROVIDERS
Network *Members who reside in the BlueCare Service Area (i.e. Vermont and the following New Hampshire bordering counties: Coos, Grafton, Cheshire and Sullivan) must use TVHP providers.* *Members who reside outside of the BlueCare Service Area must use any BlueCard Preferred Provider.*	Please visit the following website to find a doctor: www.bcbsvt.com/FindaDoctor Then select "BlueCare Access"
Out-of-Area Eligible Dependents *BlueCard Preferred Provider Network must be used.*	Please visit the following website to find a doctor: www.bcbsvt.com/FindaDoctor Then select "BlueCare Access"
Prior Approvals *All medical management rules apply.*	If you live inside of the BlueCare Service Area, Network Providers will take care of prior approvals for you. If you live outside of the BlueCare Service Area, it is your responsibility to know when you must request prior approval and to make sure your Physician submits a prior approval request. Please visit the following website for a list of Drugs and services that require prior approval: www.bcbsvt.com/priorapproval
Lifetime Maximum	Unlimited
Transplant Services Benefit Maximum	Unlimited

Group Effective Date: 01/01/2012

Custom Summary Name: BRS-TVHP-HMO-BCA-20-30-CS-250-50-1500-750 SG PPACA RX-100-5-40%-60% CY 1008300

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	NETWORK PROVIDERS	
OUTPATIENT CARE	**YOU PAY**	**PLAN PAYS**
Preventive Office Visits *Includes Well Baby, Adult Preventive, Gynecological office visits and preventive services such as laboratory and x-rays. Excludes diagnostic services.*	No member cost	100% of our allowed price
Screening Mammogram *Excludes diagnostic services*	No member cost	100% of our allowed price
Colorectal Screening *Excludes diagnostic services*	No member cost	100% of our allowed price
Primary Care Physician Office Visit	$20 co-payment	100% of our allowed price after co-payment
Specialist Office Visit	$30 co-payment	100% of our allowed price after co-payment
Outpatient Mental Health and Substance Abuse Office Visits *Requires prior approval*	$30 co-payment	100% of our allowed price after co-payment
Maternity Office Visits *One co-payment covers all routine maternity office visits*	$20 co-payment	100% of our allowed price after co-payment
Nutritional Counseling *Up to three visits; visits for treatment of diabetes do not count toward the three visit limit.*	$30 co-payment	100% of our allowed price after co-payment
Chiropractic Visits *Prior approval required after 12 visits*	$30 co-payment	100% of our allowed price after co-payment
Emergency Room Physician and Facility Services *Covered when your condition meets criteria for necessary emergency care. Includes mental health and substance abuse services.*	$250 co-payment (co-payment waived if admitted to the hospital).	100% of our allowed price after co-payment
Diagnostic Services *Includes laboratory and x-rays*	No member cost	100% of our allowed price
Outpatient Surgery *Prior approval may be required*	$750 deductible	100% of our allowed price after deductible
Outpatient Physical, Occupational, and Speech Therapy *Up to 30 visits combined per calendar year*	$30 co-payment	100% of our allowed price after co-payment
INPATIENT CARE	**YOU PAY**	**PLAN PAYS**
Inpatient Care, General Hospital *Requires pre-certification*	$1,500 deductible	100% of our allowed price after deductible
Inpatient Care, Mental Health or Substance Abuse *Requires prior approval*	$1,500 deductible	100% of our allowed price after deductible

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HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS
Inpatient Skilled Nursing *Precertification may be required*	$1,500 deductible	100% of our allowed price after deductible
Inpatient Rehabilitation Services *Requires prior approval*	$1,500 deductible	100% of our allowed price after deductible
Cardiac Rehabilitation *Up to 36 sessions per acute cardiac event; requires prior approval*	No member cost	100% of our allowed price
Home Health Services *Precertification may be required*	$30 co-payment	100% of our allowed price after co-payment
Hospice Care Services *Requires prior approval*	No member cost	100% of our allowed price
Private Duty Nursing *Up to $2,000 per member per calendar year; requires prior approval*	$30 co-payment	100% of our allowed price after co-payment
OTHER SERVICES	**YOU PAY**	**PLAN PAYS**
Ambulance *Includes emergency and routine transport; prior approval required for non-emergency transport*	$50 co-payment	100% of our allowed price after co-payment
Medical Equipment and Supplies *Prior approval may be required*	20% of our allowed price	80% of our allowed price
Vision Exam *One exam per year*	$20 co-payment	100% of our allowed price after co-payment

PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS
Retail Pharmacy Program *Up to a 30-day supply. Prior approval may be required*	$100 deductible then	After member pays $100 deductible, plan then pays
	$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
Home Delivery Pharmacy Program *Up to a 90-day supply. Prior approval may be required*	$100 deductible then	After member pays $100 deductible, plan then pays
	$12.50 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

For plans that have a deductible or co-payment for inpatient and outpatient hospital services, there is a limit of two deductibles or co-payments per family per year.

This document summarizes your health care benefits on a Plan Year basis. 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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