



BlueCare Access HSA- High Deductible Health Plan
\$2,000 / \$4,000 Individual / Family Deductible, 20% Coinsurance (Aggregate)

Created For: BRS

BENEFIT HIGHLIGHTS	NETWORK PROVIDERS
<p>Network Access <i>Members who reside in the BlueCare Services 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</i></p>	<p>Please visit the following website to find a provider: www.bcbsvt.com/FindaDoctor Then select "BlueCare Access"</p>
<p>Out-of-Area Eligible Dependents <i>You must complete a "Dependent Out-of-Area Coverage Request Form". The BlueCard Preferred Provider Network must be used.</i></p>	<p>Please visit the following website to find a provider: www.bcbsvt.com/FindaDoctor Then select "BlueCare Access"</p>
<p>Prior Approvals <i>All medical management requirements will apply</i></p>	<p>If you reside in 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 that your Physician submits a prior approval request. Please visit the following website for list Drugs and Services that require prior approval: www.bcbsvt.com/priorapproval</p>
<p>Aggregate Calendar Year Deductible <i>Aggregate: 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. Includes medical and prescription drug benefits.</i></p>	<p>\$2,000 Individual \$4,000 Family</p>
<p>Coinsurance</p>	<p>Plan pays 80% of our allowed price after deductible is met and 100% of our allowed price after Out-of-Pocket Limit is met</p>
<p>Out-of-Pocket Limit</p>	<p>\$3,000 Individual \$6,000 Family</p>
<p>Lifetime Maximum <i>Includes medical and prescription drug benefits; excludes transplant services</i></p>	<p>Unlimited</p>
<p>Transplant Services Benefit Maximum</p>	<p>\$2,000,000</p>

	NETWORK PROVIDERS	
OUTPATIENT CARE	YOU PAY	PLAN PAYS
<p>Adult Preventive Office Visits <i>Excludes diagnostic services such as laboratory and x-ray</i></p>	No member cost	100% of our allowed price
<p>Gynecological Preventive Office Visits <i>Excludes diagnostic services</i></p>	No member cost	100% of our allowed price
<p>Well Baby and Child Office Visits <i>Includes routine immunizations</i></p>	No member cost	100% of our allowed price
<p>Screening Mammogram and PAP Test <i>Excludes diagnostic services</i></p>	No member cost	100% of our allowed price
<p>Colorectal Screening <i>Excludes diagnostic services</i></p>	No member cost	100% of our allowed price



OUTPATIENT CARE	YOU PAY	PLAN PAYS
Maternity Office Visit	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
Primary Care Physician Office Visit	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
Other Specialist Office Visits	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
Mental Health and Substance Abuse Office Visits <i>Requires prior approval</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
Chiropractic Visits <i>Prior approval required after 12 visits</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
Diagnostic Services <i>Includes laboratory and x-rays. Prior approval may be required.</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
Emergency Care <i>Includes physician and facility services. Covered when your condition meets criteria for necessary emergency care.</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
Outpatient Surgery <i>Prior approval may be required</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
Outpatient Physical, Occupational, and Speech Therapy <i>Up to 30 visits combined per calendar year</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
INPATIENT CARE	YOU PAY	PLAN PAYS
Inpatient Stay (semi-private room or intensive care), includes Mental Health and Substance Abuse care <i>Prior approval required for all mental health and substance abuse treatment. Pre-certification for inpatient services required.</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS
Inpatient Skilled Nursing or Rehabilitation <i>Prior approval required for rehabilitation services</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
Home Health and Hospice Care Services	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
Cardiac Rehabilitation <i>Up to 36 sessions per acute cardiac event, requires prior approval</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
Private Duty Nursing <i>Up to \$2,000 per member per calendar year</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit



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 our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit
Medical Equipment and Supplies <i>Prior approval may be required</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible; 100% of our allowed price after out-of-pocket limit

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 our allowed price	80% of our allowed price after deductible; 100% of our allowed price 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 our allowed price	80% of our allowed price after deductible; 100% of our allowed price 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.