HSA BlueCare - High Deductible Health Plan

$2,000 / $4,000 Individual / Family Deductible, 0% Coinsurance

Created For: BRS

BENEFIT HIGHLIGHTS	NETWORK PROVIDERS
Calendar Year Deductible *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*	$2,000 Individual $4,000 Two-Person and Family
Coinsurance	Plan pays 100% of our allowed price after deductible is met
Lifetime Maximum *Includes medical and prescription drug benefits; excludes transplant services*	Unlimited
Transplant Services Benefit Maximum	$2,000,000 per member per lifetime

	NETWORK PROVIDERS	
OUTPATIENT CARE	**YOU PAY**	**PLAN PAYS**
Adult Preventive Office Visits *Excludes diagnostic services such as laboratory and x-ray*	No member cost	100% of our allowed price
Gynecological Preventive Office Visits *Excludes diagnostic services*	No member cost	100% of our allowed price
Well Baby and Child Office Visits *Includes routine immunizations*	No member cost	100% of our allowed price
Screening Mammogram and PAP Test *Excludes diagnostic services*	No member cost	100% of our allowed price
Colorectal Screening *Excludes diagnostic services*	No member cost	100% of our allowed price
Maternity Office Visits	Deductible, then No member cost	100% of our allowed price after deductible
Primary Care Physician Office Visits	Deductible, then No member cost	100% of our allowed price after deductible
Other Specialist Office Visits	Deductible, then No member cost	100% of our allowed price after deductible
Mental Health and Substance Abuse Office Visits *Requires prior approval*	Deductible, then No member cost	100% of our allowed price after deductible
Chiropractic Visits *Prior approval required after 12 visit*	Deductible, then No member cost	100% of our allowed price after deductible
Diagnostic Services *Includes laboratory and x-rays*	Deductible, then No member cost	100% of our allowed price after deductible
Emergency Care *Includes emergency room and physician services. Covered when your condition meets criteria for necessary emergency care*	Deductible, then No member cost	100% of our allowed price after deductible
Outpatient Surgery *Prior approval may be required*	Deductible, then No member cost	100% of our allowed price after deductible

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

PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS
Retail Pharmacy Program *Up to a 30-day supply. Prior approval may be required*	Deductible, then No member cost	100% of our allowed price after deductible
Mail Order Pharmacy Program *Up to a 90-day supply. Prior approval may be required*	Deductible, then No member cost	100% of our allowed price 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.