BlueCare Access HSA- High Deductible Health Plan

$3,000 / $6,000 Individual / Family Deductible, 20% Coinsurance (Stacked)

Created For: BRS

BENEFIT HIGHLIGHTS	NETWORK PROVIDERS
Network Access *Members who reside in the BlueCare Services Area (i.e. Vermont and the following New Hampshire bordering counties: Coos, Grafton, Chesire 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 provider: www.bcbsvt.com/FindaDoctor Then select "BlueCare Access"
Out-of-Area Eligible Dependents *You must complete a "Dependent Out-of-Area Coverage Request Form". The BlueCard Preferred Provider Network must be used.*	Please visit the following website to find a provider: www.bcbsvt.com/FindaDoctor Then select "BlueCare Access"
Prior Approvals *All medical management requirements will apply*	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
Stacked Calendar Year Deductible *Stacked: We will begin paying benefits for and individual once he or she has met the individual deductible. Includes medical and prescription drug benefits.*	$3,000 Individual $6,000 Family
Coinsurance	Plan pays 80% of our allowed price after deductible is met and 100% of our allowed price after Out-of-Pocket Limit is met
Out-of-Pocket Limit	$4,000 Individual $8,000 Family
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

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 *Requires prior approval*	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 *Prior approval required after 12 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
Diagnostic Services *Includes laboratory and x-rays. Prior approval may be required.*	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 *Includes physican and facility services. Covered when your condition meets criteria for necessary emergency care.*	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 *Prior approval may be required*	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 *Up to 30 visits combined per calendar year*	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 *Prior approval required for all mental health and substance abuse treatment. Pre-certification for inpatient services required.*	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 *Prior approval required for rehabilitation 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
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 *Up to 36 sessions per acute cardiac event; requires prior approval*	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 *Up to $2,000 per member per calendar year*	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 *Includes emergency and routine transport. Prior approval reqired for non-emergency transport*	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 *Prior approval may be required*	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 *Up to a 30-day supply. Prior approval my be required*	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 *Up to a 90-day supply. Prior approval may be required*	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.