BlueCare HMO

$20 PCP Co-payment, $30 Specialist Co-payment, $250 Emergency Care, $50 Ambulance, Combined $1,000 Inpatient / 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

BENEFIT HIGHLIGHTS	NETWORK PROVIDERS
Lifetime Maximum	Unlimited
Transplant Services Benefit Maximum	Unlimited

	NETWORK PROVIDERS	
OUTPATIENT CARE	**YOU PAY**	**PLAN PAYS**
Preventive Office Visits *Includes Well Baby, Adult Preventive, Gynecological Preventive office visits, includes 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 Visits	$20 co-payment	100% of our allowed price after co-payment
Specialist Office Visits	$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 is 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.*	$250 co-payment (co-payment waived if admitted as an inpatient)	100% of our allowed price after co-payment
Diagnostic Services *Includes laboratory and x-ray*	No member cost	100% of our allowed price
Outpatient Surgery *Prior approval may be required*	$1,000 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

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INPATIENT CARE	YOU PAY	PLAN PAYS
Inpatient Care, General Hospital *Requires precertification*	$1,000 deductible	100% of our allowed price after deductible
Inpatient Care, Mental Health or Substance Abuse *Requires prior approval*	$1,000 deductible	100% of our allowed price after deductible
HOME CARE AND REHABILITATION SERVICES	**YOU PAY**	**PLAN PAYS**
Inpatient Skilled Nursing *Precertification may be required*	$1,000 deductible	100% of our allowed price after deductible
Inpatient Rehabilitation Services *Requires prior approval*	$1,000 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 ambulance transport*	$50 co-payment	100% of our allowed price after co-payment
Medical Equipment and Supplies *Prior approval may be required*	20% of allowed price	80% of 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

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.

Standard Plan Name: TVHP-HMO-$20-$30-DC-$250-$50-$1,000 PPACA Compliant/(Rx-$100-$5-40%-60%) VE20 Rider 1006095

Template Name: TVHP-HMO-DC-2-2011-SG

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For plans that include an inpatient and outpatient deductible, the deductibles are limited to two deductibles per family per year