BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

CDHP Blue - Consumer Directed Health Plan

$4,000 / $8,000 Individual / Family Deductible, 20% Member Coinsurance
PPACA Compliant
Wellness Drugs - $0 Deductible then, $5 Generic Co-payment, 40% Preferred Brand-Name Coinsurance, or 60% Non-Preferred Brand Name Coinsurance ((Note: All other prescription drugs are subject to the plan year deductible, then 20% member coinsurance)
Vision Exam $20 co-payment

Created For: Business Resource Services

BENEFIT HIGHLIGHTS	NETWORK PROVIDERS
Your Plan Year: *January 1, 2012 through December 31, 2012* *All accumulators, such as deductibles, out-of-pocket limits and benefit limits apply to your Plan Year for all medical and prescription drug benefits.*	
Plan Year Deductible *Includes medical 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. Excludes Wellness Drugs.*	$4,000 Individual $8,000 Two-Person and Family
Coinsurance	Member pays 20% of our allowed price after deductible is met. Plan pays 80% of our allowed price after deductible is met.
Plan Year Out-of-Pocket Limit *Includes medical and prescription drug deductible. If you have a two-person or family membership, the entire Out-of-Pocket Limit must be met by any combination of family members before benefits are paid by the plan at 100%. Includes Wellness Drugs*	$5,000 Individual $10,000 Two-Person and Family
Lifetime Maximum	Unlimited
Transplant Services Maximum	Unlimited

	NETWORK PROVIDERS	
OUTPATIENT CARE	**YOU PAY**	**PLAN PAYS**
Preventive Office Visits *Includes Well Baby, Adult Preventive, Gynecological Preventive; includes preventive services such as laboratory and x-ray. Excludes diagnostic services.*	No member cost	100% of our allowed price
Screening Mammogram *Excludes diagnostic services*	No member cost	100% of our allowed price
Screening Colonoscopy *Excludes diagnostic services*	No member cost	100% of our allowed price
Primary Care Physician Office Visits	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Specialist Office Visits	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Outpatient Mental Health and Substance Abuse Office Visits and Services *Requires prior approval*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible

Group Effective Date: 01/01/2012

Custom Summary Name: BRS-BCBS-HSA-4000-5000-20%-SG-AGG-PPACA-RX-0-5-40%-60% CY 1008316

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OUTPATIENT CARE	YOU PAY	PLAN PAYS
Maternity Office Visits	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Nutritional Counseling *Up to three visits; visits for treatment of diabetes do not count toward the three-visit limit*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Chiropractic Visits *Prior approval required after 12 visits*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Emergency Room Physician and Facility Services *Covered when your condition meets criteria for necessary emergency care. Includes Mental Health and Substance Abuse services.*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Diagnostic Services *Includes diagnostic laboratory and x-ray*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Outpatient Surgery *Prior approval may be required*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Outpatient Physical, Occupational, and Speech Therapy *Up to 30 visits combined per Plan Year*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
INPATIENT CARE	**YOU PAY**	**PLAN PAYS**
Inpatient Care, General Hospital Admission *Pre-certification is required*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Inpatient Care, Mental Health or Substance Abuse Admission *Prior approval required*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
HOME CARE AND REHABILITATION SERVICES	**YOU PAY**	**PLAN PAYS**
Inpatient Skilled Nursing *Requires pre-certification*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Inpatient Rehabilitation *Requires prior approval*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Home Health and Hospice Care Services *Home Health Services require pre-certification after initial evaluation; Hospice Care Services require prior approval.*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
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
Private Duty Nursing *Up to $2,000 per member per Plan Year; requires prior approval*	Deductible, then 20% of our allowed price	80% 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 20% of our allowed price	80% of our allowed price after deductible

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OTHER SERVICES	YOU PAY	PLAN PAYS
Medical Equipment and Supplies *Prior approval may be required.*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
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*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Home Delivery Pharmacy Program *Up to 90-day supply. Prior approval may be required*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Wellness Drugs *Eligible Wellness Drugs can change and will be updated from time to time. We will inform you of changes using newsletters and other mailings. To get the most up-to-date listing, you may visit our website at www.bcbsvt.com or call customer service at (888) 882-3600.*		
Retail Wellness Pharmacy Program *Up to a 30-day supply. Prior approval may be required*	$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 Wellness Pharmacy Program *Up to 90-day supply. Prior approval may be required*	$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 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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