



**BlueCross BlueShield
of Vermont**

Independent Licensees of the Blue Cross and Blue Shield Association.



CDHP BlueCare - Consumer Directed Health Plan

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

PPACA Compliant

Wellness Drugs - \$0 Deductible, \$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)

Vision Exam \$20 co-payment

Created For: Business Resource Services

BENEFIT HIGHLIGHTS	NETWORK PROVIDERS
Your Plan Year: <i>January 1, 2012 through December 31, 2012</i> <i>All accumulators, such as deductibles, out-of-pocket limits and benefit limits apply to your Plan Year for all medical and prescription drug benefits.</i>	
Plan Year Deductible <i>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.</i> <i>Excludes Wellness Drugs.</i>	\$2,000 Individual \$4,000 Two-Person and Family
Coinsurance	Plan pays 100% of allowed price after deductible is met
Plan Year Out-of-Pocket Limit <i>Includes medical and prescription drug benefits.</i>	\$2,000 Individual \$4,000 Two-person and Family
Lifetime Maximum	Unlimited
Transplant Services Maximum	Unlimited

OUTPATIENT CARE	NETWORK PROVIDERS	
	YOU PAY	PLAN PAYS
Preventive Office Visits <i>Includes Well Baby, Adult Preventive and Gynecological Preventive office visits. Includes preventive services such as laboratory and x-rays.</i> <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price
Screening Mammogram <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price
Colorectal Screening <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price
Primary Care Physician Office Visits	Deductible, then no member cost	100% of our allowed price after deductible
Specialist Office Visits	Deductible, then no member cost	100% of our allowed price after deductible
Outpatient Mental Health and Substance Abuse Office Visits and Services <i>Requires prior approval</i>	Deductible, then no member cost	100% of our allowed price after deductible
Maternity Office Visits	Deductible, then no member cost	100% of our allowed price after deductible

Group Effective Date: 01/01/2012

Custom Summary Name: TVHP-HSA-2000-4000-0% AGG-SG-Rx-0-5-40%-60% PPACA CY 1008315



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OUTPATIENT CARE	YOU PAY	PLAN PAYS
Nutritional Counseling <i>Up to three visits; visits for the treatment of diabetes do not count toward the three-visit limit</i>	Deductible, then no member cost	100% of our allowed price after deductible
Chiropractic Visits <i>Prior approval required after 12 visits.</i>	Deductible, then no member cost	100% of our allowed price after deductible
Emergency Room Physician and Facility Services <i>Covered when your condition meets criteria for necessary emergency care. Includes emergency mental health and substance abuse services.</i>	Deductible, then no member cost	100% of our allowed price after deductible
Diagnostic Services <i>Includes laboratory and x-rays.</i>	Deductible, then no member cost	100% of our allowed price after deductible
Outpatient Surgery <i>Prior approval may be required</i>	Deductible, then no member cost	100% of our allowed price after deductible
Outpatient Physical, Occupational, and Speech Therapy <i>Up to 30 visits combined per Plan Year.</i>	Deductible, then no member cost	100% of our allowed price after deductible
INPATIENT CARE	YOU PAY	PLAN PAYS
Inpatient Care- includes Mental Health and Substance Abuse Care <i>Prior approval required for all mental health and substance abuse treatment. Pre-certification is required for inpatient services.</i>	Deductible, then no member cost	100% of our allowed price after deductible
HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS
Inpatient Skilled Nursing and Rehabilitation Services <i>Pre-certification may be required for inpatient skilled nursing. Prior approval required for rehabilitation</i>	Deductible, then no member cost	100% of our allowed price after deductible
Home Health and Hospice Care Services <i>Pre-certification may be required for Home Health Services. Prior approval required for Hospice Care.</i>	Deductible, then no member cost	100% of our allowed price after deductible
Cardiac Rehabilitation <i>Up to 36 sessions per acute cardiac event; requires prior approval</i>	Deductible, then no member cost	100% of our allowed price after deductible
Private Duty Nursing <i>Up to \$2,000 per member per Plan Year. Prior approval is required</i>	Deductible, then no member cost	100% of our allowed price after deductible
OTHER SERVICES	YOU PAY	PLAN PAYS
Ambulance <i>Includes emergency and routine transport. Prior approval required for non-emergency transport.</i>	Deductible, then no member cost	100% of our allowed price after deductible
Medical Equipment and Supplies <i>Prior approval may be required</i>	Deductible, then no member cost	100% of our allowed price after deductible

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OTHER SERVICES	YOU PAY	PLAN PAYS
Vision Exam <i>One exam per year</i>	\$20 co-payment	100% of our allowed price after co-payment

PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS
Retail Pharmacy Program <i>Up to a 30-day supply. Prior approval may be required</i>	Deductible, then no member cost	100% of our allowed price after deductible
Home Delivery Pharmacy Program <i>Up to 90-day supply. Prior approval may be required</i>	Deductible, then no member cost	100% of our allowed price after deductible
Wellness Drugs <i>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.</i>		
Retail Wellness Pharmacy Program <i>Up to a 30-day supply. Prior approval may be required.</i>	\$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 Program <i>Up to a 90-day supply. Prior approval may be required.</i>	\$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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