

Blue Edge Business CDHP 2:

Exclusive Provider Organization (PCP) \$6,550/\$13,100, 0% co-insurance

Aggregate deductible

\$6,550 if you are on an individual plan
\$13,100 if you are on a two-person or family plan

Aggregate out-of-pocket limit

\$6,550 if you are on an individual plan
\$9,200/\$13,100 if you are on a two-person or family plan

Rx drug out-of-pocket limit

\$1,650 if you are on an individual plan
\$3,300 if you are on a two-person or family plan

This plan has an aggregate deductible. If you are on a two-person or family plan, your family members' combined expenses must meet the entire \$13,100 deductible each year before we begin to pay benefits.

This plan has an aggregate out-of-pocket limit. If you are on a two-person or family plan, your out-of-pocket limits are \$9,200 per individual or \$13,100 aggregate family. Once you reach the out-of-pocket limit in a year, we pay 100% of the allowed amount for all covered expenses. Medical and prescription drug out-of-pocket limits are combined.

YOU MUST USE NETWORK PROVIDERS	YOU PAY	PLAN PAYS
OUTPATIENT CARE		
<p>preventive care Includes well baby, adult preventive, gynecological preventive office visits; includes preventive services such as laboratory, x-ray, screening mammograms, PAP tests and colonoscopies. Excludes diagnostic services.</p>	No cost.	100% of the allowed amount.
<p>primary care provider office visits</p>	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
<p>mental health and substance use disorder office visits may require prior approval</p>		
<p>specialist office visits may require prior approval</p>		
<p>chiropractic care prior approval required after 12 visits per year</p>		
<p>outpatient physical, occupational and speech therapy up to 30 visits combined per calendar year (You have a separate but equal visit limit for rehabilitative services.)</p>		
<p>diagnostic services includes labs, x-ray, etc.; may require prior approval</p>		
<p>imaging (CT/RET scans, MRI) may require prior approval</p>		
<p>outpatient surgery prior approved may be required</p>		
<p>emergency care</p>		
<p>urgent care care at an urgent care center</p>		
CARE DURING PREGNANCY		
<p>maternity office visits</p>	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
<p>inpatient delivery</p>		
INPATIENT CARE		
<p>inpatient care, general hospital Includes mental health and substance abuse and other inpatient care</p>	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
HOME CARE AND REHABILITATION SERVICES		
<p>inpatient skilled nursing or rehabilitation prior approval required for rehabilitation</p>	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
<p>home health and hospice care services prior approval required</p>		
<p>private duty nursing prior approval required. Up to 14 hours per member per calendar year</p>		
OTHER SERVICES		
<p>ambulance prior approval required for non-emergency transport</p>	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
<p>medical equipment and supplies prior approval may be required</p>		
<p>vision exam one exam per year (use Vision Service Plan providers)</p>	\$20 co-payment.	After your co-payment, 100% of the allowed amount..
PRESCRIPTION DRUGS		
<p>prescription drugs (including home delivery) prior approval may be required</p>	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
<p>wellness drugs visit www.bcbsvt.com/wellnessrx to find a list.</p>	<ul style="list-style-type: none"> \$12 co-payment for generics 40% co-insurance for preferred brand-name drugs 60% co-insurance for non-preferred brand-name drugs. 	After your co-payment and co-insurance, 100% of the allowed amount..



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Please note that this page contains only a summary of information. Your Summary Plan Description and other contract documents govern your benefits.