

# Blue Edge Business CDHP 1:

## Exclusive Provider Organization (PCP) \$3,000/\$6,000 deductible, 0% Co-insurance

### Aggregate deductible

\$3,000 if you are on an individual plan  
\$6,000 if you are on a two-person or family plan

### Aggregate out-of-pocket limit

\$3,000 if you are on an individual plan  
\$6,000 if you are on a two-person or family plan

### Rx drug out-of-pocket limit

\$1,700 if you are on an individual plan  
\$3,400 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 \$6,000 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, once your family members' combined out-of-pocket expenses meet the \$6,000 maximum each year, we pay 100% of the allowed amount for all covered expenses. Prescription drugs have a lower out-of-pocket limit.

YOU MUST USE NETWORK PROVIDERS	YOU PAY	PLAN PAYS
<b>OUTPATIENT CARE</b>		
<b>preventive care</b> 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.	No cost.	100% of the allowed amount.
<b>primary care provider office visits</b>	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
<b>mental health and substance use disorder office visits</b> may require prior approval		
<b>specialist office visits</b> may require prior approval		
<b>chiropractic care</b> prior approval required after 12 visits per year		
<b>outpatient physical, occupational and speech therapy</b> up to 30 visits combined per calendar year (You have a separate but equal visit limit for rehabilitative services.)		
<b>diagnostic services</b> includes labs, x-ray, etc.; may require prior approval		
<b>imaging (CT/RET scans, MRI)</b> may require prior approval		
<b>outpatient surgery</b> prior approved may be required		
<b>emergency care</b>		
<b>urgent care</b> care at an urgent care center		
<b>CARE DURING PREGNANCY</b>		
<b>maternity office visits</b>	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
<b>inpatient delivery</b>		
<b>INPATIENT CARE</b>		
<b>inpatient care, general hospital</b> Includes mental health and substance abuse and other inpatient care	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
<b>HOME CARE AND REHABILITATION SERVICES</b>		
<b>inpatient skilled nursing or rehabilitation</b> prior approval required for rehabilitation	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
<b>home health and hospice care services</b> prior approval required		
<b>private duty nursing</b> prior approval required. Up to 14 hours per member per calendar year		
<b>OTHER SERVICES</b>		
<b>ambulance</b> prior approval required for non-emergency transport	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
<b>medical equipment and supplies</b> prior approval may be required		
<b>vision exam</b> one exam per year (use Vision Service Plan providers)	\$20 co-payment.	After your co-payment, 100% of the allowed amount.
<b>PRESCRIPTION DRUGS</b>		
<b>prescription drugs (including home delivery)</b> prior approval may be required	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
<b>wellness drugs</b> visit <a href="http://bluecrossvt.org/vtbluerx">bluecrossvt.org/vtbluerx</a> to find a list.	\$5 co-payment for generics 40% co-insurance for preferred brand-name 60% co-insurance for non-preferred brand-name	After you meet your co-payment or co-insurance, 100% of the allowed amount.



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

# DISCLAIMERS

## General Exclusions

While your health plan covers a broad array of necessary services and supplies, it doesn't cover every possible medical expense. If you would like to review the list of general exclusions before enrolling, visit [bluecrossvt.org/contracts](http://bluecrossvt.org/contracts), click on the plan in which you are enrolling and read the chapter entitled "General Exclusions." Once you enroll, you will receive an Outline of Coverage and a link to your Certificate of Coverage. Please read both carefully as they govern your specific benefits.

## How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at [bluecrossvt.org/privacypolicies](http://bluecrossvt.org/privacypolicies).

## NOTICE: Discrimination is Against the Law

Blue Cross® and Blue Shield® of Vermont (Blue Cross VT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-status.

Blue Cross VT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

Blue Cross VT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, contact Whitney Standefer-Smith, [civilrightscordinator@bcbsvt.com](mailto:civilrightscordinator@bcbsvt.com).

If you believe that Blue Cross VT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Whitney Standefer-Smith, Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583 (TTY/TDD: 711), fax (802) 229-0511, or email [civilrightscordinator@bcbsvt.com](mailto:civilrightscordinator@bcbsvt.com). You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, Whitney Standefer-Smith, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically or through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW Room 509F  
HHH Building Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>

**For free language-assistance service, call (800) 247-2583 (TTY/TDD: 711).**

ARABIC	للحصول على خدمات المساعدة اللغوية المجانية ، اتصل (800) 2583 247 (TTY/TDD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).
CHINESE	如需免费语言协助服务，请致电，(800) 247-2583 (TTY/TDD: 711)。Rú xū miǎnfèi yǔyán xiézhù fúwù, qǐng zhìdiàn (800) 247-2583 TTY/TDD: 711).
CUSHITE (OROMO)	Tajaajila gargaarsa afaanii bilisaa argachuuf, (800) 247-2583 (TTY/TDD: 711) bilbili.
FRENCH	Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/TDD: 711).
GERMAN	Für kostenlose Sprachunterstützungsdienste rufen Sie (800) 247-2583 (TTY/TDD: 711) an.
ITALIAN	Per i servizi di assistenza linguistica gratuiti, chiamare il numero (800) 247-2583 (TTY/TDD: 711).
JAPANESE	無料の言語支援サービスについては、(800) 247-2583 (TTY/TDD: 711)。Muryō no gengo shien sābisu ni tsuite wa, (800) 247-2583 (TTY/TDD: 711) made o denwa kudasai.
NEPALI	निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस्, (800) 247-2583 (TTY/TDD: 711). Niḥśulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583 (TTY/TDD: 711).
PORTUGUESE	Para serviços gratuitos de assistência linguística, ligue para (800) 247-2583 (TTY/TDD: 711).
RUSSIAN	Чтобы получить бесплатную языковую помощь, позвоните по телефону (800) 247-2583 (TTY/TDD: 711).
SERBO-CROATIAN (SERBIAN)	За бесплатне услуге језичке помоћи позовите (800) 247-2583 (TTY/TDD: 711). Za besplatne usluge jezičke pomoći pozovite (800) 247-2583 (TTY/TDD: 711).
SPANISH	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583 (TTY/TDD: 711).
THAI	สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร, (800) 247-2583 (TTY/TDD: 711). Sǎhrǎb brikār chǎwfyǎelǎx dǎn phǎs'ǎ frī thor (800) 247-2583 (TTY/TDD: 711).
UKRAINIAN	Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583 (TTY/TDD: 711). Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583 (TTY/TDD: 711)
VIETNAMESE	Đổi với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).