Blue Edge Business CDHP 1:

Exclusive Provider Organization (PCP) $3,000/$6,000 deductible, 0% Coinsurance

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
$1,750 if you are on an individual plan
$3,500 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
OUTPATIENT CARE		
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.	No cost.	100% of the allowed amount.
primary care provider office visits	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
mental health and substance use disorder office visits may require prior approval		
specialist office visits may require prior approval		
chiropractic care prior approval required after 12 visits per year		
outpatient physical, occupational and speech therapy up to 30 visits combined per calendar year (You have a separate but equal visit limit for habilitative services.)		
diagnostic services includes labs, x-ray, etc.; may require prior approval		
imaging (CT/PET scans, MRI) may require prior approval		
outpatient surgery prior approved may be required		
emergency care		
urgent care care at an urgent care center		
CARE DURING PREGNANCY		
maternity office visits	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
inpatient delivery		
INPATIENT CARE		
inpatient care, general hospital Includes mental health and substance abuse and other inpatient care	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
HOME CARE AND REHABILITATION SERVICES		
inpatient skilled nursing or rehabilitation prior approval required for rehabilitation	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
home health and hospice care services prior approval required		
private duty nursing prior approval required. Up to 14 hours per member per calendar year		
OTHER SERVICES		
ambulance prior approval required for non-emergency transport	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
medical equipment and supplies prior approval may be required		
vision exam one exam per year (use Vision Service Plan providers)	$20 copayment.	After your copayment, 100% of the allowed amount.
PRESCRIPTION DRUGS		
prescription drugs (including home delivery) prior approval may be required	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
wellness medications visit www.bcbsvt.com/wellnessrx to find a list.	$5 copayment for generics 40% coinsurance for preferred brand-name 60% coinsurance for non-preferred brand-name	After you meet your copayment or coinsurance, 100% of the allowed amount.

BlueCross BlueShield of Vermont
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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.