Blue Edge Business Co-pay 2:

Exclusive Provider Organization (PCP) $30/$50 OV, $3,000/$6,000 deductible then copayments

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

Stacked out-of-pocket limit
$12,000 if you are on an individual plan
$24,000 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 a stacked deductible. *If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.*

This plan has a stacked out-of-pocket limit. *If you have other family members on this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. Medical and prescription drug limits are combined.*

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	$30 copayment per visit.	After your copayment, 100% of the allowed amount.
mental health and substance use disorder office visits may require prior approval		
specialist office visits may require prior approval	$50 copayment per visit.	
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	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
imaging (CT/PET scans, MRI) may require prior approval	Deductible, then $1,750 copayment per visit.	After you meet your deductible and any applicable copayments, 100% of the allowed amount.
outpatient surgery prior approved may be required	Deductible, then $2,000 copayment per visit; deductible for physician fee.	
emergency care	Deductible, then $500 copayment per visit; deductible for physician fee.	
urgent care care at an urgent care center	$50 copayment per visit.	After your copayment, 100% of the allowed amount.
CARE DURING PREGNANCY		
maternity office visits	$30 copayment per visit.	After copayment, 100% of the allowed amount.
inpatient delivery	Deductible, then $500 copayment per day; deductible for physician fee.	After you meet your deductible and copayment, 100% of the allowed amount.
INPATIENT CARE		
inpatient care, general hospital Includes mental health and substance abuse and other inpatient care	Deductible, then $500 copayment per day; deductible for physician fee.	After you meet your deductible and copayment, 100% of the allowed amount.
HOME CARE AND REHABILITATION SERVICES		
inpatient skilled nursing or rehabilitation prior approval required for rehabilitation	Deductible, then $500 copayment per day.	After you meet your deductible and copayment, 100% of the allowed amount.
home health and hospice care services prior approval required	Deductible, then no charge.	After you meet your deductible, 100% of the allowed amount.
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 $500 copayment per transport.	After you meet your deductible and copayment, 100% of the allowed amount.
medical equipment and supplies prior approval may be required	Deductible, then $100 copayment.	After you meet your deductible and copayment, 100% of the allowed amount.
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	• $10 copayment for generics • $50 copayment for preferred brand-name drugs • $75 for non-preferred brand-name drugs.	After your copayment, 100% of the allowed amount.
wellness medications visit www.bcbsvt.com/wellnessrx to find a list.	Same as prescription drugs.	Same as prescription drugs.

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.