



**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

Vision Exam \$20

BENEFIT HIGHLIGHTS	NETWORK PROVIDERS
Calendar 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>	\$2,000 Individual \$4,000 Two-Person and Family
Coinsurance	Plan pays 100% of allowed price after deductible is met
Calendar Out-of-Pocket Limit	\$2,000 Individual \$4,000 Two-person and Family
Lifetime Maximum	Unlimited
Transplant Services Benefit Maximum	Unlimited

	NETWORK PROVIDERS	
OUTPATIENT CARE	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. 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
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

Standard Plan Name: TVHP-HSA-\$2,000-0% AGG PPACA Compliant VE20 Rider 1006072

Template Name: TVHP-HSA-AGG-2011-LG



CDHP BlueCare - Consumer Directed Health Plan

OUTPATIENT CARE	YOU PAY	PLAN PAYS
Outpatient Physical, Occupational, and Speech Therapy <i>Up to 30 visits combined per calendar 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 calendar 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
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 a 90-day supply. Prior approval may be required</i>	Deductible, then no member cost	100% of our allowed price after deductible

This document summarizes the benefits of your health care plan per calendar year. 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.