



**BlueCross BlueShield  
of Vermont**

*An Independent Licensee of the Blue Cross and Blue Shield Association.*

**Created for: VACE**

**CDHP Blue - Consumer Directed Health Plan**

**\$2,450 / \$4,900 Individual / Family Stacked Deductible, 10% Member Coinsurance**

**\$5,950 / \$11,900 Individual / Family Out-of-Pocket Limit**

**Wellness Drugs - \$0 Generic Co-payment, 50% Preferred Brand-Name, and 50% Non-Preferred Brand-Name Member Coinsurance**

**All other prescription drugs are subject to the Plan Year deductible and 50% coinsurance**

**PPACA Compliant**

**Vision Exam \$20**

BENEFIT HIGHLIGHTS	ALL PROVIDERS
Your Plan Year: <i>January 1, 2012 through December 31, 2012</i> <i>All accumulators, such as deductibles, out-of-pocket limits and benefit limits apply to your Plan Year for all medical and prescription drug benefits.</i>	
Plan Year Deductible <i>Includes medical and prescription drug benefits. Plan pays benefits for an individual after he or she has met the individual deductible.</i>	\$2,450 Individual \$4,900 Two-Person and Family
Coinsurance	Plan pays 90% of allowed price after deductible is met.
Plan Year Out-of-Pocket Limit <i>Includes Plan Year Deductible</i>	\$5,950 Individual \$11,900 Two-Person and Family
Lifetime Maximum	Unlimited
Transplant Services Benefit Maximum	Unlimited

OUTPATIENT CARE	ALL PROVIDERS	
	YOU PAY	PLAN PAYS
Preventive Office Visits <i>Includes Well Baby, Adult Preventive, Gynecological Preventive Office Visits; includes preventive services such as laboratory and x-ray. 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
Screening Colonoscopy <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price
Primary Care Physician Office Visits	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Specialist Office Visits	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Outpatient Mental Health and Substance Abuse Office Visits and Services <i>Requires prior approval</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible

Group Effective Date: 01/01/2012

Custom Summary Name: VACE-BCBS-HSA-2450-0%-SG-STK-PPACA CY 1008426 WS60



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<b>OUTPATIENT CARE</b>	<b>YOU PAY</b>	<b>PLAN PAYS</b>
Maternity Office Visits	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Nutritional Counseling <i>Up to three visits; visits for treatment of diabetes do not count toward the three-visit limit</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Chiropractic Visits <i>Prior approval required after 12 visits</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Emergency Room Physician and Facility Services <i>Covered when your condition meets criteria for necessary emergency care. Includes mental health and substance abuse services.</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Diagnostic Services <i>Includes diagnostic laboratory and x-ray</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Outpatient Surgery <i>Prior approval may be required</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Outpatient Physical, Occupational, and Speech Therapy <i>Up to 30 visits combined per Plan Year</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
<b>INPATIENT CARE</b>	<b>YOU PAY</b>	<b>PLAN PAYS</b>
Inpatient Care, General Hospital Admission <i>Pre-certification is required for inpatient services.</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Inpatient Care, Mental Health or Substance Abuse Admission <i>Prior approval required for all mental health and substance abuse treatment.</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
<b>HOME CARE AND REHABILITATION SERVICES</b>	<b>YOU PAY</b>	<b>PLAN PAYS</b>
Inpatient Skilled Nursing <i>Requires pre-certification</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Inpatient Rehabilitation Services <i>Requires prior approval</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Home Health and Hospice Care Services <i>Home Health Services require pre-certification; Hospice Care Services require prior approval.</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Cardiac Rehabilitation <i>Up to 36 sessions per acute cardiac event; requires prior approval</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Private Duty Nursing <i>Up to \$2,000 per member per Plan Year; requires prior approval</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible

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OTHER SERVICES	YOU PAY	PLAN PAYS
Ambulance <i>Includes emergency and routine transport. Prior approval required for non-emergency transport.</i>	Deductible, then 10% of our allowed price	90% of our allowed price after deductible
Medical Equipment and Supplies <i>Prior approval may be required.</i>	Deductible, then 10% of our allowed price	90% 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 WELLNESS DRUGS*	YOU PAY	PLAN PAYS
Generic	No member cost	100% of our allowed price
Preferred and Non-Preferred Brand-Name	50% coinsurance	50% of our allowed price
ALL OTHER PRESCRIPTION DRUGS		
Retail Pharmacy Program <i>Up to a 30-day supply. Prior approval may be required</i>	Deductible, then 50% coinsurance	50% of our allowed price
Home Delivery Pharmacy Program <i>Up to 90-day supply. Prior approval may be required</i>	Deductible, then 50% coinsurance	50% of our allowed price

*\*Eligible Wellness Drugs can change and will be updated from time to time. We will inform you of changes using newsletters and other mailings. To get the most up-to-date listing, you may visit our website at [www.bcbsvt.com](http://www.bcbsvt.com) or call customer service at (888) 882-3600.*

**This document summarizes your health care benefits on a Plan Year basis. 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.**

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