CDHP BlueCare - Consumer Directed Health Plan

$5,000 / $10,000 Individual / Family Deductible, 0% Coinsurance
PPACA Compliant
Vision Exam and Materials $20
Wellness Drugs - $0 Deductible, $5 Generic Co-payment, 40% Preferred Brand-Name Member Coinsurance, or 60% Non-Preferred Brand-Name Member Coinsurance

Created For: Vermont State Dental Society

BENEFIT HIGHLIGHTS	ALL PROVIDERS
Your Plan Year: *January 1, 2012 through December 31, 2012* *All accumulators, such as deductibles, out-of-pocket limits and benefit limits apply to your Plan Year for all medical and prescription drug benefits.*	
Plan Year Deductible *Includes medical and prescription drug benefits. Plan pays benefits for an individual after he or she has met the individual deductible. Excludes Wellness drugs.*	$5,000 Individual $10,000 Two-Person and Family
Coinsurance	Plan pays 100% of allowed price after deductible is met
Plan Year Out-of-Pocket Limit	$5,000 Individual $10,000 Two-person and Family
Lifetime Maximum	Unlimited
Transplant Services Maximum	Unlimited

	ALL PROVIDERS	
OUTPATIENT CARE	**YOU PAY**	**PLAN PAYS**
Preventive Office Visits *Includes Well Baby, Adult Preventive and Gynecological Preventive office visits. Includes preventive services such as laboratory and x-rays. Excludes diagnostic services*	No member cost	100% of our allowed price
Screening Mammogram *Excludes diagnostic services*	No member cost	100% of our allowed price
Colorectal Screening *Excludes diagnostic services*	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 *Requires prior approval*	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

Group Effective Date: 01/01/2012

Custom Summary Name: VSDS-TVHP-HSA-5000-0%-SG STK PPACA Wellness Rx-5-40%-60% VEM20 Rider CY 1008335

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OUTPATIENT CARE	YOU PAY	PLAN PAYS
Nutritional Counseling *Up to three visits; visits for the treatment of diabetes do not count toward the three-visit limit*	Deductible, then no member cost	100% of our allowed price after deductible
Chiropractic Visits *Prior approval required after 12 visits.*	Deductible, then no member cost	100% of our allowed price after deductible
Emergency Room Physician and Facility Services *Covered when your condition meets criteria for necessary emergency care. Includes mental health and substance abuse services.*	Deductible, then no member cost	100% of our allowed price after deductible
Diagnostic Services *Includes laboratory and x-rays.*	Deductible, then no member cost	100% of our allowed price after deductible
Outpatient Surgery *Prior approval may be required*	Deductible, then no member cost	100% of our allowed price after deductible
Outpatient Physical, Occupational, and Speech Therapy *Up to 30 visits combined per Plan Year.*	Deductible, then no member cost	100% of our allowed price after deductible
INPATIENT CARE	**YOU PAY**	**PLAN PAYS**
Inpatient Care, General Hospital Admission *Pre-certification is required for inpatient services.*	Deductible, then no member cost	100% of our allowed price after deductible
Inpatient Care, Mental Health or Substance Abuse Admission *Prior approval required for all mental health and substance abuse treatment.*	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 *Pre-certification may be required for inpatient skilled nursing. Prior approval required for rehabilitation services*	Deductible, then no member cost	100% of our allowed price after deductible
Home Health and Hospice Care Services *Pre-certification may be required for Home Health services. Prior approval required for Hospice Care.*	Deductible, then no member cost	100% of our allowed price after deductible
Cardiac Rehabilitation *Up to 36 sessions per acute cardiac event; requires prior approval*	Deductible, then no member cost	100% of our allowed price after deductible
Private Duty Nursing *Up to $2,000 per member per Plan Year. Prior approval is required*	Deductible, then no member cost	100% of our allowed price after deductible

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OTHER SERVICES	YOU PAY	PLAN PAYS
Ambulance *Includes emergency and routine transport. Prior approval required for non-emergency transport.*	Deductible, then no member cost	100% of our allowed price after deductible
Medical Equipment and Supplies *Prior approval may be required*	Deductible, then no member cost	100% of our allowed price after deductible
Vision Exam and Materials *One exam per year, materials per VSP allowance*	$20 co-payment each for exam and materials	100% of our allowed price after co-payment

PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS
Retail Pharmacy Program *Up to a 30-day supply. Prior approval may be required.*	Deductible, then no member cost	100% of our allowed price after deductible
Home Delivery Pharmacy Program *Up to a 90-day supply. Prior approval may be required.*	Deductible, then no member cost	100% of our allowed price after deductible
Wellness Drugs *Excluded from Plan Year Deductible. 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 or call customer service at (888) 882-3600.*		
Retail Wellness Pharmacy Program *Up to a 30-day supply. Prior approval may be required*	$5 Generic co-payment	100% after co-payment
	40% Preferred Brand-Name coinsurance	60% Preferred Brand-Name coinsurance
	60% Non-Preferred Brand-Name coinsurance	40% Non-Preferred Brand-Name coinsurance
Home Delivery Wellness Pharmacy Program *Up to a 90-day supply. Prior approval may be required*	$12.50 Generic co-payment	100% after co-payment
	40% Preferred Brand-Name coinsurance	60% Preferred Brand-Name coinsurance
	60% Non-Preferred Brand-Name coinsurance	40% Non-Preferred Brand-Name coinsurance

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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