



**BlueCross BlueShield
of Vermont**

Independent Licensees of the Blue Cross and Blue Shield Association.



BlueCare HMO

\$20 PCP Co-payment, \$30 Specialist Co-payment, \$250 Emergency Care Co-payment, \$50 Ambulance Co-payment, \$500 Inpatient and \$200 Outpatient Co-payments

PPACA Compliant

Prescription Drugs - \$100 Deductible, \$5 Generic Co-payment, 40% Preferred Brand-Name Member Coinsurance, or 60% Non-Preferred Brand-Name Member Coinsurance

Vision Exam \$20 co-payment

Created For: Business Resource Services

BENEFIT HIGHLIGHTS	NETWORK 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>	
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, 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	\$20 co-payment	100% of our allowed price after co-payment
Specialist Office Visits	\$30 co-payment	100% of our allowed price after co-payment
Mental Health and Substance Abuse Office Visits <i>Requires prior approval</i>	\$30 co-payment	100% of our allowed price after co-payment
Maternity Office Visits <i>One co-payment covers all maternity office visits</i>	\$20 co-payment	100% of our allowed price after co-payment
Nutritional Counseling <i>Up to three visits; visits for treatment of diabetes do not count toward the three-visit limit</i>	\$30 co-payment	100% of our allowed price after co-payment
Chiropractic Visits <i>Prior approval is required after 12 visits</i>	\$30 co-payment	100% of our allowed price after co-payment

Group Effective Date: 01/01/2012

Custom Summary Name: BRS-TVHP-HMO-20-30-CS-250-50-500-200 SG-RX-100-5-40%-60% CY VE20 Rider 1008299



**BlueCross BlueShield
of Vermont**

Independent Licensees of the Blue Cross and Blue Shield Association.



BlueCare HMO

OUTPATIENT CARE	YOU PAY	PLAN PAYS
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>	\$250 co-payment (co-payment waived if admitted as an inpatient)	100% of our allowed price after co-payment
Diagnostic Services <i>Includes laboratory and x-ray</i>	No member cost	100% of our allowed price
Outpatient Surgery <i>Prior approval may be required</i>	\$200 co-payment	100% of our allowed price after co-payment
Outpatient Physical, Occupational, and Speech Therapy <i>Up to 30 visits combined per Plan Year</i>	\$30 co-payment	100% of our allowed price after co-payment
INPATIENT CARE	YOU PAY	PLAN PAYS
Inpatient Care, General Hospital <i>Requires precertification</i>	\$500 co-payment	100% of our allowed price after co-payment
Inpatient Care, Mental Health or Substance Abuse <i>Requires prior approval</i>	\$500 co-payment	100% of our allowed price after co-payment
HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS
Inpatient Skilled Nursing <i>Precertification may be required</i>	\$500 co-payment	100% of our allowed price after co-payment
Inpatient Rehabilitation <i>Requires prior approval</i>	\$500 co-payment	100% of our allowed price after co-payment
Cardiac Rehabilitation <i>Up to 36 sessions per acute cardiac event; requires prior approval</i>	No member cost	100% of our allowed price
Home Health Services <i>Precertification may be required</i>	\$30 co-payment	100% of our allowed price after co-payment
Hospice Care <i>Prior approval required</i>	No member cost	100% of our allowed price
Private Duty Nursing <i>Up to \$2,000 per member per Plan Year; requires prior approval</i>	\$30 co-payment	100% of our allowed price after co-payment
OTHER SERVICES	YOU PAY	PLAN PAYS
Ambulance <i>Includes emergency and routine transport; prior approval required for non-emergency ambulance transport</i>	\$50 co-payment	100% of our allowed price after co-payment

Group Effective Date: 01/01/2012

Custom Summary Name: BRS-TVHP-HMO-20-30-CS-250-50-500-200 SG-RX-100-5-40%-60% CY VE20 Rider 1008299



**BlueCross BlueShield
of Vermont**

Independent Licensees of the Blue Cross and Blue Shield Association.



BlueCare HMO

OTHER SERVICES	YOU PAY	PLAN PAYS
Medical Equipment and Supplies <i>Prior approval may be required</i>	20% of allowed price	80% of allowed price
Vision Exam <i>One exam per year</i>	\$20 copayment	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>	\$100 deductible then	After member pays \$100 deductible, plan then pays
	\$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 Pharmacy Program <i>Up to a 90-day supply. Prior approval may be required</i>	\$100 deductible then	After member pays \$100 deductible, plan then pays
	\$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

For plans that include an inpatient and outpatient co-payments or deductibles, the co-payments or deductibles are limited to two deductibles per family per year

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.

Group Effective Date: 01/01/2012

Custom Summary Name: BRS-TVHP-HMO-20-30-CS-250-50-500-200 SG-RX-100-5-40%-60% CY VE20 Rider 1008299