



**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, \$2,000 Inpatient Deductible and \$1,000 Outpatient Deductible

PPACA Compliant

Prescription Drugs - \$100 Deductible then \$5 Generic, \$25 Preferred Brand-Name, or \$50 Non-Preferred Brand-Name

Co-payments

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-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
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 routine 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-250-50-2000-1000 SG PPACA RX-100-5-25-50 CY VE20 Rider 1008318



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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>	\$1,000 deductible	100% of our allowed price after deductible
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>	\$2,000 deductible	100% of our allowed price after deductible
Inpatient Care, Mental Health or Substance Abuse <i>Requires prior approval</i>	\$2,000 deductible	100% of our allowed price after deductible
HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS
Inpatient Skilled Nursing <i>Precertification may be required</i>	\$2,000 deductible	100% of our allowed price after deductible
Inpatient Rehabilitation <i>Requires prior approval</i>	\$2,000 deductible	100% of our allowed price after deductible
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

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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 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>	\$100 deductible then	After \$100 deductible,
	\$5 Generic co-payment	100% after co-payment
	\$25 Preferred Brand-Name co-payment	100% after co-payment
	\$50 Non-Preferred Brand-Name co-payment	100% after co-payment
Home Delivery Pharmacy Program <i>Up to a 90-day supply. Prior approval may be required</i>	\$100 deductible then	After \$100 deductible,
	\$12.50 Generic co-payment	100% after co-payment
	\$62.50 Preferred Brand-Name co-payment	100% after co-payment
	\$125 Non-Preferred Brand-Name co-payment	100% after co-payment

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.

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