



BlueCross BlueShield of Vermont

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

Vermont Freedom Plan - Preferred Provider Organization (PPO)

\$1,500 / \$3,000 Individual / Family Deductible, 20% Coinsurance, \$30 PCP / \$30 Specialist Office Visit

Co-payment, \$7,500 / \$15,000 Individual / Family Out-of-Pocket Limit

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	PREFERRED PROVIDERS	NON-PREFERRED 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	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family
Coinsurance	Plan pays 80% of our allowed price after you meet your deductible. You pay 20% of our allowed price up to your out-of-pocket limit.	Plan pays 70% of our allowed price after you meet your deductible. You pay 30% of our allowed price up to your out-of-pocket limit.
Plan Year Out-of-Pocket Limit	\$7,500 Individual \$15,000 Family When you meet your out-of-pocket limit, we pay 100% of our allowed price.	\$15,000 Individual \$30,000 Family When you meet your out-of-pocket limit, we pay 100% of our allowed price.
Lifetime Maximum	Unlimited	Unlimited
Transplant Services Benefit Maximum	Unlimited	Unlimited

OUTPATIENT CARE	PREFERRED PROVIDERS		NON-PREFERRED PROVIDERS	
	YOU PAY	PLAN PAYS	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	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Screening Mammogram <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price	No member cost	100% of our allowed price
Screening Colonoscopy <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Primary Care Physician Office Visits	\$30 co-payment	100% of our allowed price after co-payment	Deductible, then 30% of our allowed price	70% of our allowed price after deductible

Group Effective Date: 01/01/2012

Custom Summary Name: BRS-BCBS-PPO-30-DC-250-50-1500-3000-20%-SG-RX-100-5-25-50 CY 1008298



Vermont Freedom Plan - Preferred Provider Organization (PPO)

OUTPATIENT CARE	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Specialist Office Visits	\$30 co-payment	100% of our allowed price after co-payment	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Outpatient Mental Health and Substance Abuse Office Visits <i>Requires prior approval</i>	\$30 co-payment	100% of our allowed price after co-payment	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Maternity Office Visits	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% 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>	\$30 co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit
Chiropractic Visits <i>Prior approval required after 12 visits</i>	\$30 co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit
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	100% of our allowed price after co-payment	\$250 co-payment	100% of our allowed price after co-payment
Diagnostic Services <i>Includes diagnostic laboratory and x-ray</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Outpatient Surgery <i>Prior approval may be required</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Outpatient Physical, Occupational, and Speech Therapy <i>Up to 30 visits combined per Plan Year</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
INPATIENT CARE	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Inpatient Care, General Hospital Admission <i>Requires pre-certification</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Inpatient Care, Mental Health or Substance Abuse Admission <i>Requires prior approval</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Inpatient Skilled Nursing <i>Requires pre-certification</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	100% of charges	Not a covered benefit

Group Effective Date: 01/01/2012

Custom Summary Name: BRS-BCBS-PPO-30-DC-250-50-1500-3000-20%-SG-RX-100-5-25-50 CY 1008298



BlueCross BlueShield of Vermont

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

Vermont Freedom Plan - Preferred Provider Organization (PPO)

HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Inpatient Rehabilitation <i>Requires prior approval</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	100% of charges	Not a covered benefit
Home Health and Hospice Care Services <i>Home Health Services require pre-certification after initial evaluation; Hospice Care Services require prior approval</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Cardiac Rehabilitation <i>Up to 36 sessions per acute cardiac event; requires prior approval</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	100% of charges	Not a covered benefit
Private Duty Nursing <i>Up to \$2,000 per member per Plan Year; requires prior approval</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
OTHER SERVICES	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Ambulance <i>Includes emergency and routine transport. Prior approval required for non-emergency transport</i>	\$50 co-payment	100% of our allowed price after co-payment	\$50 co-payment	100% of our allowed price after co-payment
Medical Equipment and Supplies <i>Prior approval may be required</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 30% of our allowed price	70% 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	100% of charges	Not a covered benefit

PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS	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,	100% of charges	Not a covered benefit
	\$5 Generic co-payment	100% after co-payment	100% of charges	Not a covered benefit
	\$25 Preferred Brand-Name co-payment	100% after co-payment	100% of charges	Not a covered benefit
	\$50 Non-Preferred Brand-Name co-payment	100% after co-payment	100% of charges	Not a covered benefit
Home Delivery Pharmacy Program <i>Up to a 90-day supply. Prior approval may be required</i>	\$100 deductible then	After \$100 deductible,	100% of charges	Not a covered benefit
	\$12.50 Generic co-payment	100% after co-payment	100% of charges	Not a covered benefit
	\$62.50 Preferred Brand-Name co-payment	100% after co-payment	100% of charges	Not a covered benefit

Group Effective Date: 01/01/2012

Custom Summary Name: BRS-BCBS-PPO-30-DC-250-50-1500-3000-20%-SG-RX-100-5-25-50 CY 1008298



BlueCross BlueShield of Vermont

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

Vermont Freedom Plan - Preferred Provider Organization (PPO)

PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
	\$125 Non-Preferred Brand-Name co-payment	100% after co-payment	100% of charges	Not a covered benefit

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-BCBS-PPO-30-DC-250-50-1500-3000-20%-SG-RX-100-5-25-50 CY 1008298