



## Vermont Freedom Plan - Preferred Provider Organization (PPO)

**\$5,000 / \$10,000 Individual / Family Deductible, 20% Coinsurance, \$30 Office Visit, \$7,500 / \$15,000**

**Individual / Family Out-of-Pocket Limit**

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

**Created For: BRS**

BENEFIT HIGHLIGHTS	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
<b>Calendar Year Deductible</b>	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family
<b>Coinsurance</b>	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.
<b>Calendar Year Out-of-Pocket Limit</b>	\$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.
<b>Lifetime Maximum</b>	\$2,000,000 per member per lifetime	\$2,000,000 per member per lifetime
<b>Transplant Services Benefit Maximum</b>	\$2,000,000 per member per lifetime	\$2,000,000 per member per lifetime

OUTPATIENT CARE	PREFERRED PROVIDERS		NON-PREFERRED PROVIDERS	
	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
<b>Adult Preventive Office Visits</b> <i>Excludes diagnostic services such as laboratory and x-ray</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
<b>Gynecological Preventive Office Visits</b> <i>Excludes diagnostic services</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
<b>Well Baby and Child Office Visits</b> <i>Includes routine immunizations</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
<b>Screening Mammogram</b> <i>Excludes diagnostic services</i>	\$25 co-payment	100% of our allowed price after co-payment	\$25 co-payment	100% of our allowed price after co-payment
<b>Colorectal Screening</b> <i>Excludes diagnostic services</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
<b>Other Physician Office Visits</b>	\$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
<b>Mental Health and Substance Abuse Office Visits</b> <i>Requires prior approval</i>	\$30 co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit
<b>Maternity Office Visits</b>	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
<b>Nutritional Counseling</b> <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



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OUTPATIENT CARE	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
<b>Chiropractic Visits</b> <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
<b>Emergency Room</b> <i>Covered when your condition meets criteria for necessary emergency care</i>	\$150 co-payment	100% of our allowed price after co-payment	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
<b>Diagnostic Services</b> <i>Includes 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
<b>Outpatient Surgery</b> <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
<b>Outpatient Physical, Occupational, and Speech Therapy</b> <i>Up to 30 visits combined per calendar 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
<b>Inpatient Care, General Hospital</b> <i>Requires precertification</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
<b>Inpatient Care, Mental Health or Substance Abuse</b> <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 CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
<b>Inpatient Skilled Nursing</b>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	100% of charges	Not a covered benefit
<b>Inpatient Rehabilitation</b> <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
<b>Home Health and Hospice Care Services</b>	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
<b>Cardiac Rehabilitation</b> <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
<b>Private Duty Nursing</b> <i>Up to \$2,000 per member per calendar 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
<b>Ambulance</b> <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
<b>Medical Equipment and Supplies</b> <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



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PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
<b>Retail Pharmacy Program</b> <i>Up to a 30-day supply. Prior approval may be required</i>	\$100 deductible then	After \$100 deductible and co-payment or coinsurance	100% of charges	Not a covered benefit
	\$5 generic co-payment	100% after co-payment	100% of charges	Not a covered benefit
	40% preferred brand-name coinsurance	60% preferred brand-name coinsurance	100% of charges	Not a covered benefit
	60% non-preferred brand-name coinsurance	40% non-preferred brand-name coinsurance	100% of charges	Not a covered benefit
<b>Mail Order Pharmacy Program</b> <i>Up to a 90-day supply. Prior approval may be required</i>	\$100 deductible then	After \$100 deductible and co-payment or coinsurance	100% of charges	Not a covered benefit
	\$10 generic co-payment	100% after co-payment	100% of charges	Not a covered benefit
	40% preferred brand-name coinsurance	60% preferred brand-name coinsurance	100% of charges	Not a covered benefit
	60% non-preferred brand-name coinsurance	40% non-preferred brand-name coinsurance	100% of charges	Not a covered benefit

*Diabetic medications are covered like any other medication*

*DME: up to \$25,000 per member per year maximum. Prosthetics and Diabetic Supplies are not included in maximum*

*Deductible will accumulate January 1 through December 31 with no carry-over to the following year.*

*Benefit Exclusion Rider*

*This document summarizes the benefits of your health care plan per calendar year. 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.*

*Benefits paid by your health plan for services rendered by Preferred Providers and Non-Preferred Providers are combined and applied to a common Lifetime Maximum dollar amount.*

*Benefits paid by your health plan for services rendered by Preferred Providers and Non-Preferred Providers are combined and applied to a common lifetime Transplant Services Benefit Maximum dollar amount.*