



BlueCross BlueShield of Vermont

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

Vermont Freedom Plan - Preferred Provider Organization (PPO)

\$750 / \$1,500 Individual / Family Deductible, 20% Coinsurance, \$30 PCP / \$30 Specialist Office Visit

Co-payment, \$3,750 / \$7,500 Individual / Family Out-of-Pocket Limit

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

Created For: Business Resource Services

BENEFIT HIGHLIGHTS	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Your Plan Year: January 1, 2012 through December 31, 2012 <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	\$750 Individual \$1,500 Family	\$1,500 Individual \$3,000 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	\$3,750 Individual \$7,500 Family When you meet your out-of-pocket limit, we pay 100% of our allowed price.	\$7,500 Individual \$15,000 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-30-30-DC-250-50-1000-3000-20%-Rx-100-5-40%-60%-SG-PPACA CY 1008292



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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

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HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Inpatient Rehabilitation Services <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 requires pre-certification after initial evaluation; Hospice Care Services 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
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
	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
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
	40% Preferred Brand-Name coinsurance	60% Preferred Brand-Name coinsurance	100% of charges	Not a covered benefit

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	60% Non-Preferred Brand-Name coinsurance	40% Non-Preferred Brand-Name coinsurance	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.

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