



**Created for: VACE**

**Vermont Freedom Plan - Preferred Partner Organization (PPO)**

**\$4,000 / \$8,000 Individual / Family Deductible, 20% Coinsurance, \$30 PCP / \$50 Specialist Office Visit**

**\$8,000 / \$16,000 Individual / Family Out-of-Pocket Limit**

**Prescription Drugs - \$3 Generic Co-payment, 50% Preferred and Non Preferred Brand-Name Coinsurance**

**\$2,500 / \$5,000 Individual / Family Out-of-Pocket Limit for prescription drugs**

**PPACA Compliant**

**Vision Exam \$20**

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	\$4,000 Individual \$8,000 Family	\$8,000 Individual \$16,000 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 60% of our allowed price after you meet your deductible. You pay 40% of our allowed price up to your out-of-pocket limit.
Medical Plan Year Out-of-Pocket Limit <i>Includes Plan Year Deductible, co-payments and coinsurance.</i>	\$8,000 Individual \$16,000 Family When you meet your out-of-pocket limit, we pay 100% of our allowed price.	\$16,000 Individual \$32,000 Family When you meet your out-of-pocket limit, we pay 100% of our allowed price.
Pharmacy Plan Year Out-of-Pocket Limit	\$2,500 Individual \$5,000 Family When you meet your out-of-pocket limit, we pay 100% of our allowed price.	Not a covered benefit
Lifetime Maximum	Unlimited	Unlimited
Transplant Services 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 40% of our allowed price	60% 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 40% of our allowed price	60% of our allowed price after deductible
Primary Care Physician Office Visits	\$30 co-payment	100% of our allowed price after co-payment	Deductible, then 40% of our allowed price	60% of our allowed price after deductible

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Custom Summary Name: VACE-BCBS-PPO-30-50-DC-4000-8000-20%-RX-2500-3-9-50% SG PPACA 1007953 XS47



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<b>OUTPATIENT CARE</b>	<b>YOU PAY</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>	<b>PLAN PAYS</b>
Specialist Office Visits	\$50 co-payment	100% of our allowed price after co-payment	Deductible, then 40% of our allowed price	60% of our allowed price after deductible
Outpatient Mental Health and Substance Abuse Office Visits <i>Requires prior approval.</i>	\$50 co-payment	100% of our allowed price after co-payment	Deductible, then 40% of our allowed price	60% 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 40% of our allowed price	60% 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>	\$50 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>	\$50 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>	\$150 co-payment (co-payment waived if admitted as an inpatient)	100% of our allowed price after co-payment	\$150 co-payment (co-payment waived if admitted as an inpatient)	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 40% of our allowed price	60% 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 40% of our allowed price	60% of our allowed price after deductible
Outpatient Physical, Occupational, and Speech Therapy <i>Up to 30 visits combined per Plan Year.</i>	\$50 co-payment	100% of our allowed price after co-payment	Deductible, then 40% of our allowed price	60% of our allowed price after deductible
<b>INPATIENT CARE</b>	<b>YOU PAY</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>	<b>PLAN PAYS</b>
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 40% of our allowed price	60% 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 40% of our allowed price	60% of our allowed price after deductible
<b>HOME CARE AND REHABILITATION SERVICES</b>	<b>YOU PAY</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>	<b>PLAN PAYS</b>
Inpatient Skilled Nursing <i>Requires Precertification.</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 <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 Precertification 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 40% of our allowed price	60% 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 40% of our allowed price	60% 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>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
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 40% of our allowed price	60% 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>	\$3 Generic co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit
	50% Preferred Brand-Name coinsurance	50% of our allowed price	100% of charges	Not a covered benefit
	50% Non-Preferred Brand-Name coinsurance	50% of our allowed price	100% of charges	Not a covered benefit
Home Delivery Pharmacy Program <i>Up to a 90-day supply. Prior approval may be required.</i>	\$9 Generic co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit
	50% Preferred Brand-Name coinsurance	50% of our allowed price	100% of charges	Not a covered benefit
	50% Non-Preferred Brand-Name coinsurance	50% of our allowed price	100% of charges	Not a covered benefit

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**BlueCross BlueShield  
of Vermont**

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

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*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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