BlueCross BlueShield of Vermont

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

Comprehensive Plan

$1,000 / $2,000 Individual / Family Deductible, 20% Coinsurance, $1,500 / $3,000 Individual / Family Out-of-Pocket Limit

Prescription Drugs - $0 Deductible, $0 Generic, $15 Preferred Brand-Name, or $40 Non-Preferred Brand-Name Co-payments

Created For: VEHI Plan 15

BENEFIT HIGHLIGHTS	ALL PROVIDERS
Calendar Year Deductible	$1,000 Individual $2,000 Family
Coinsurance	Plan pays 80% of allowed price after you meet your deductible. You pay 20% of allowed price up to your out-of-pocket limit
Calendar Year Out-of-Pocket Limit	$1,500 Individual $3,000 Family
Lifetime Maximum *Includes medical and prescription drug benefits; excludes transplant services*	Unlimited
Transplant Services Benefit Maximum	$2,000,000 per member per lifetime

	ALL PROVIDERS	
OUTPATIENT CARE	YOU PAY	PLAN PAYS
Primary Care Office Visit	$20 co-payment	100% of our allowed price after co-payment
Adult Preventive Office Visit *Excludes diagnostic services such as laboratory and x-rays*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Gynecological Preventive Office Visit *Excludes diagnostic services*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Well Baby and Child Office Visits *Includes routine immunizations*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Screening Mammogram *Excludes diagnostic services*	$20 co-payment	100% of our allowed price after co-payment
Colorectal Screening *Excludes diagnostic services*	$20 co-payment	100% of our allowed price after co-payment
Maternity Office Visits	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Other Office Visits	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Mental Health and Substance Abuse Office Visits *Managed mental health services, prior approval required*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Nutritional Counseling *Up to three visits; visits for treatment of diabetes do not count toward the three -visit limit.*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Chiropractic Visits *Prior approval required after 12 visit.*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Diagnostic Services *Includes laboratory and x-ray.*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Emergency Care *Covered when your condition meets criteria for necessary emergency care*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible

BlueCross BlueShield of Vermont

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

Comprehensive Plan

OUTPATIENT CARE	YOU PAY	PLAN PAYS
Outpatient Surgery *Prior approval may be required*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Outpatient Physical, Occupational, and Speech Therapy *Up to 30 visits combined*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
INPATIENT CARE	**YOU PAY**	**PLAN PAYS**
Inpatient Care, General Hospital Admission *Requires precertification*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Inpatient Care, Mental Health or Substance Abuse Admission *Managed mental health services, prior approval required*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
HOME CARE AND REHABILITATION SERVICES	**YOU PAY**	**PLAN PAYS**
Inpatient Skilled Nursing	Deductible, then 20% of our allowed price	80% of allowed price after deductible
Inpatient Rehabilitation *Requires prior approval*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Cardiac Rehabilitation *Up to 36 sessions per acute cardiac event; requires prior approval*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Home Health Care	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Hospice Care	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Private Duty Nursing *Up to $2,000 per member per calendar year; requires prior approval*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
OTHER SERVICES	**YOU PAY**	**PLAN PAYS**
Ambulance *Includes emergency and routine transport. Prior approval required for non-emergency transport*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible
Medical Equipment and Supplies *Prior approval may be required*	Deductible, then 20% of our allowed price	80% of our allowed price after deductible

PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS
Retail Pharmacy Program *Up to a 30-day supply. Prior approval may be required*	$0 Generic co-payment	100% after co-payment
	$15 preferred brand-name co-payment	100% after co-payment
	$40 non-preferred brand-name co-payment	100% after co-payment
Mail Order Pharmacy Program *Up to a 90-day supply. Prior approval may be required*	$0 generic co-payment	100% after co-payment
	$30 preferred brand-name co-payment	100% after co-payment
	$80 non-preferred brand-name co-payment	100% after co-payment

Any portion of your deductible applied for services you have after September 30th each year will be applied toward your next year's deductible as well.

Diabetic Medications will be covered at 100% of our allowed price. Diabetic DME will take a costshare. Waiver of waiting periods applied to policy.

Federal Mental Health Parity.

Effective Date: 01/01/2010
Plan Name: VEHI plan 15 1002269
Template Name: XXX-XXX-XXX

BlueCross BlueShield of Vermont

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

Comprehensive Plan

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.

Effective Date: 01/01/2010
Plan Name: VEHI plan 15 1002269
Template Name: XXX-XXX-XXX