



BlueCross BlueShield of Vermont

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

Indemnity J Plan

\$15 PCP Co-payment, \$15 Specialist Co-payment, \$100 Ancillary Deductible, 20% Coinsurance

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

Created For: VEHI Plan 2

BENEFIT HIGHLIGHTS	ALL PROVIDERS
Deductible <i>Combined deductible for private duty nursing, ambulance, and medical equipment and supplies; limited to three deductibles per family per year</i>	\$100 per member
Coinsurance <i>Applies to private duty nursing, ambulance, and medical equipment and supplies after deductible</i>	20% member coinsurance
Out-Of-Pocket Limit <i>Combined out-of-pocket limit for private duty nursing, ambulance, and medical equipment and supplies</i>	\$500 per member
Lifetime Maximum <i>Includes medical and prescription drug benefits</i>	Unlimited
Transplant Services Benefit Maximum	\$2,000,000

OUTPATIENT CARE	ALL PROVIDERS	
	YOU PAY	PLAN PAYS
Adult Preventive Office Visits <i>Excludes diagnostic services such as laboratory and x-ray</i>	\$15 co-payment	100% of our allowed price after co-payment
Gynecological Preventive Office Visits	\$15 co-payment	100% of our allowed price after co-payment
Well Baby and Child Office Visits <i>Includes routine immunizations</i>	\$15 co-payment	100% of our allowed price after co-payment
Screening Mammogram <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price
Colorectal Screening <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price
Maternity Care	No member cost	100% of our allowed price
Office Visits with Primary Care Physician	\$15 co-payment	100% of our allowed price after co-payment
Office Visits with Specialist	\$15 co-payment	100% of our allowed price after co-payment
Mental Health and Substance Abuse Office Visits <i>Managed mental health services, requires prior approval</i>	\$15 co-payment	100% of our allowed price after co-payment
Chiropractic Visits <i>Prior approval is required after 12 visits</i>	\$15 co-payment	100% of our allowed price after co-payment
Outpatient Physical, Occupational, and Speech Therapy <i>Up to 30 visits combined per calendar year</i>	No member cost	100% of our allowed price
Diagnostic Services <i>Includes Laboratory and X-ray</i>	No member cost	100% of our allowed price

Effective Date: 01/01/2010
 Plan Name: VEHI plan 2 1002243
 Template Name: XXX-XXX-XXX



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OUTPATIENT CARE	YOU PAY	PLAN PAYS
Emergency Care <i>Covered when your condition meets criteria for necessary emergency care.</i>	No member cost	100% of our allowed price
Outpatient Surgery <i>Prior approval may be required</i>	No member cost	100% of our allowed price
INPATIENT CARE	YOU PAY	PLAN PAYS
Inpatient Care, General Hospital <i>Requires precertification</i>	No member cost	100% of our allowed price
Inpatient Care, Mental Health or Substance Abuse <i>Requires prior approval</i>	No member cost	100% of our allowed price
HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS
Inpatient Skilled Nursing	No member cost	100% of our allowed price
Inpatient Rehabilitation <i>Requires prior approval</i>	No member cost	100% of our allowed price
Home Health Care	No member cost	100% of our allowed price
Hospice Care	No member cost	100% of our allowed price
Private Duty Nursing <i>Up to \$2,000 per member per calendar year; requires prior approval</i>	\$100 deductible, then 20% of our allowed price, up to \$500 out-of-pocket limit	80% of our allowed price after deductible and coinsurance. 100% after out-of-pocket limit.
OTHER SERVICES	YOU PAY	PLAN PAYS
Ambulance <i>Includes emergency and routine transport. Prior approval required for non-emergency transport</i>	\$100 deductible, then 20% of our allowed price, up to \$500 out-of-pocket limit	80% of our allowed price after deductible and coinsurance. 100% after out-of-pocket maximum
Medical Equipment and Supplies <i>Prior approval may be required</i>	\$100 deductible, then 20% of our allowed price, up to \$500 out-of-pocket limit	80% of our allowed price after deductible and coinsurance. 100% after out-of-pocket maximum

PRESCRIPTION DRUGS	YOU PAY	PLAN PAYS
Retail Pharmacy Program <i>Up to a 30-day supply. Prior approval may be required</i>	\$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 <i>Up to a 90-day supply. Prior approval may be required</i>	\$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

Diabetic Medications and Supplies will be covered at 100% of our allowed price. Waiver of waiting periods applied to policy.

Federal Mental Health Parity.

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.

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.