



Vermont Health Partnership - Point of Service (POS)

**Preferred Benefits: \$10 PCP Co-payment, \$20 Specialist Co-payment, \$0 Inpatient Co-payment, \$0
Outpatient Co-payment**

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

Created For: VEHI Plan 17

BENEFIT HIGHLIGHTS	PREFERRED PROVIDERS	STANDARD PROVIDERS
Calendar Year Deductible	\$0 Individual \$0 Two-Person and Family	\$500 Individual \$1,000 Two-Person and Family
Coinsurance	0% of our allowed price	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.
Calendar Year Out-of-Pocket Limit	\$0 Individual \$0 Two-Person and Family	\$2,500 Individual \$5,000 Two-Person and Family
Lifetime Maximum <i>Includes medical and prescription drug benefits; excludes transplant services</i>	Unlimited	Unlimited
Transplant Services Benefit Maximum	\$2,000,000 per member per lifetime	\$2,000,000 per member per lifetime

OUTPATIENT CARE	PREFERRED PROVIDERS		STANDARD PROVIDERS	
	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Office Visits with Primary Care Physician <i>Excludes diagnostic services such as laboratory and x-ray</i>	\$10 co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit
Gynecological Preventive Office Visits	\$20 co-payment	100% of allowed price after co-payment	30% of our allowed price after deductible	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
Colorectal Screening <i>Excludes diagnostic services</i>	No member cost	100% of our allowed price	30% of our allowed price after deductible	70% of our allowed price after deductible
Maternity Office Visits <i>One preferred co-payment covers all maternity office visits</i>	\$20 co-payment	100% of our allowed price after co-payment	30% of our allowed price after deductible	70% of our allowed price after deductible
Specialist Office Visits	\$20 co-payment	100% of our allowed price after co-payment	30% of our allowed price after deductible	70% of our allowed price after deductible
Mental Health and Substance Abuse Office Visits <i>Requires prior approval</i>	\$20 co-payment	100% of our allowed price after co-payment	30% of our allowed price after deductible	70% of our allowed price after deductible
Nutritional Counseling <i>Up to three visits; visits for the treatment of diabetes do not count toward the three-visit limit</i>	\$20 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>	\$20 co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit
Diagnostic Services <i>Includes laboratory and x-ray</i>	No member cost	100% of our allowed price.	30% of our allowed price after deductible	70% of our allowed price after deductible



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OUTPATIENT CARE	YOU PAY	PLAN PAYS	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	No standard benefits	No standard benefits
Outpatient Surgery <i>Prior approval may be required</i>	No member cost	100% of our allowed price	30% of our allowed price after deductible	70% of our allowed price after deductible
Physical, Occupational, and Speech Therapy <i>Up to 30 visits combined per calendar year</i>	\$20 co-payment	100% of our allowed price after co-payment	30% of our allowed price after deductible	70% of our allowed price after deductible
INPATIENT CARE	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Inpatient Care, General Hospital <i>Requires precertification</i>	No member cost	100% of our allowed price	30% of our allowed price after deductible	70% of our allowed price after deductible
Inpatient Care, Mental Health or Substance Abuse <i>Requires prior approval</i>	No member cost	100% of our allowed price	30% of our allowed price after deductible	70% of our allowed price after deductible
HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Inpatient Skilled Nursing	No member cost	100% of our allowed price	30% of our allowed price after deductible	70% of our allowed price after deductible
Inpatient Rehabilitation <i>Requires prior approval</i>	No member cost	100% of our allowed price	100% of charges	Not a covered benefit
Home Health and Hospice Care Services	No member cost	100% of our allowed price	30% of our allowed price after deductible	70% of our allowed price after deductible
Cardiac Rehabilitation <i>Up to 36 sessions per acute cardiac event; requires prior approval</i>	No member cost	100% of our allowed price	100% of charges	Not a covered benefit
Private Duty Nursing <i>Up to \$2,000 per member per calendar year; requires prior approval</i>	\$20 co-payment	100% of our allowed price after co-payment	30% of our allowed price after deductible	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	No standard benefits	No standard benefits
Medical Equipment and Supplies <i>Prior approval may be required</i>	\$100 deductible, then 20% of our allowed price	80% of our allowed price after deductible	100% of charges	Not a covered benefit
Vision Exam <i>One exam per member, per year</i>	\$20 co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit



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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>	\$0 Generic co-payment	100% after co-payment	100% of charges	Not a covered benefit
	\$15 preferred brand-name co-payment	100% after co-payment	100% of charges	Not a covered benefit
	\$40 non-preferred brand-name co-payment	100% after co-payment	100% of charges	Not a covered benefit
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	100% of charges	Not a covered benefit
	\$30 preferred brand-name co-payment	100% after co-payment	100% of charges	Not a covered benefit
	\$80 non-preferred brand-name co-payment	100% after co-payment	100% of charges	Not a covered benefit

Diabetic Medications and Supplies will be covered at 100% of our allowed price.

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.

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.