



BlueCross BlueShield of Vermont

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

Vermont Freedom Plan - Preferred Provider Organization (PPO)

\$200 / \$400 Individual / Family Deductible, 20% Coinsurance, \$10 Office Visit, \$600 / \$1,200

Individual / Family Out-of-Pocket Limit

Prescription Drugs - \$0 Deductible, \$10 Generic, \$15 Preferred Brand-Name, or \$15 Non-Preferred Brand-Name Co-payments

Personalized For: City of Burlington

| BENEFIT HIGHLIGHTS | PREFERRED PROVIDERS | NON-PREFERRED PROVIDERS |
|--|---|---|
| Calendar Year Deductible | \$200 Individual \$400 Family | \$500 Individual \$1,000 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. |
| Calendar Year Out-of-Pocket Limit | \$600 Individual \$1,200 Family When you meet your out-of-pocket limit, we pay 100% of our allowed price. | \$1,500 Individual \$2,000 Family When you meet your out-of-pocket limit, we pay 100% of our allowed price. |
| Lifetime Maximum | \$2,000,000 per member per lifetime | \$2,000,000 per member per lifetime |
| Transplant Services Benefit Maximum | \$2,000,000 per member per lifetime | \$2,000,000 per member per lifetime |

| OUTPATIENT CARE | PREFERRED PROVIDERS | | NON-PREFERRED PROVIDERS | |
|--|---|---|---|---|
| | YOU PAY | PLAN PAYS | YOU PAY | PLAN PAYS |
| Routine Physical Examinations <i>Includes annual OB-GYN exam, well-child care, screening mammograms and screening PSA test</i> | No member cost | 100% of our allowed price | Deductible, then 30% of our allowed price | 70% of our allowed price after deductible |
| Other Physician Office Visits | \$10 co-payment | 100% of our allowed price after co-payment | Deductible, then 30% of our allowed price | 70% of our allowed price after deductible |
| Mental Health and Substance Abuse Office Visits <i>Requires prior approval</i> | \$10 co-payment | 100% of our allowed price after co-payment | 100% of charges | Not a covered benefit |
| 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> | \$10 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> | \$10 co-payment | 100% of our allowed price after co-payment | 100% of charges | Not a covered benefit |
| Emergency Room Physician | \$10 co-payment | 100% of our allowed priced after co-payment | Deductible, then 30% of our allowed price | 70% of our allowed after deductible |
| Emergency Room <i>Covered when your condition meets criteria for necessary emergency care</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 |

Effective Date: 07/01/2009

Standard Plan Name: BCBS-PPO-\$10-\$10-DC-\$200-\$600-20%/(Rx-0-\$10-\$15-\$15) 1001423

Template Name: BCBS-PPO-DC-2009



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| OUTPATIENT CARE | YOU PAY | PLAN PAYS | YOU PAY | PLAN PAYS |
|--|---|---|---|---|
| Diagnostic Services <i>Includes 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 calendar 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 <i>Requires precertification</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 <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 CARE AND REHABILITATION SERVICES | YOU PAY | PLAN PAYS | YOU PAY | PLAN PAYS |
| Inpatient Skilled Nursing | 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 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 | 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 calendar 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> | 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 30% of our allowed price | 70% of our allowed price after deductible |



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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> | \$10 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 |
| | \$15 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> | \$20 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 |
| | \$30 non-preferred brand-name co-payment | 100% after co-payment | 100% of charges | Not a covered benefit |

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 Maximum dollar amount.

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.