



Vermont Freedom Plan - Preferred Provider Organization (PPO)

\$500 / \$1,000 Individual / Family Deductible, 20% Coinsurance, \$15 PCP / \$15 Specialist Office Visit

Co-payment, \$1,500 / \$3,000 Individual / Family Out-of-Pocket Limit

Prescription Drugs - \$0 Deductible, \$10 Generic, \$15 Preferred Brand-Name, or \$30 Non-Preferred Brand-Name Co-payments

PPACA Grandfathered

Vision Exam \$20

Created For: Vermont Law School

BENEFIT HIGHLIGHTS	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Calendar Year Deductible	\$500 Individual \$1,000 Family	\$1,000 Individual \$2,000 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	\$1,500 Individual \$3,000 Family When you meet your out-of-pocket limit, we pay 100% of our allowed price.	\$3,000 Individual \$6,000 Family When you meet your out-of-pocket limit, we pay 100% of our allowed price.
Lifetime Maximum	Unlimited	Unlimited
Transplant Services Benefit Maximum	Unlimited	Unlimited

OUTPATIENT CARE	PREFERRED PROVIDERS		NON-PREFERRED PROVIDERS	
	YOU PAY	PLAN PAYS	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	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Gynecological Preventive Office Visits <i>Excludes diagnostic services</i>	\$15 co-payment	100% of our allowed price after co-payment	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Well Baby and Child Office Visits <i>Includes routine immunizations</i>	\$15 co-payment	100% of our allowed price after co-payment	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Screening Mammogram <i>Excludes diagnostic services</i>	\$15 co-payment	100% of our allowed price after co-payment	\$15 co-payment	100% of our allowed price
Screening Colonoscopy <i>Excludes diagnostic services</i>	\$15 co-payment	100% of our allowed price after co-payment	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Primary Care Physician Office Visits	\$15 co-payment	100% of our allowed price after co-payment	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Specialist Office Visits	\$15 co-payment	100% of our allowed price after co-payment	Deductible, then 30% of our allowed price	70% of our allowed price after deductible

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OUTPATIENT CARE	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Outpatient Mental Health and Substance Abuse Office Visits <i>Requires prior approval</i>	\$15 co-payment	100% of our allowed price after co-payment	Deductible, then 30% of our allowed price	70% of our allowed price after deductible
Outpatient Mental Health and Substance Abuse Services <i>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
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>	\$15 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>	\$15 co-payment	100% of our allowed price after co-payment	100% of charges	Not a covered benefit
Emergency Room Physician <i>Covered when your condition meets criteria for necessary emergency care.</i>	\$15 co-payment	100% of our allowed price after co-payment	\$15 co-payment	100% of our allowed price after co-payment
Emergency Room Facility <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 20% of our allowed price	80% of our allowed price after deductible
Emergency Mental Health and Substance Abuse Services <i>Covered when your condition meets criteria for necessary medical care; include facility and physician services</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
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 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 Admission <i>Requires pre-certification</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 Admission <i>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
HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Inpatient Skilled Nursing <i>Requires pre-certification</i>	Deductible, then 20% of our allowed price	80% of our allowed price after deductible	100% of charges	Not a covered benefit
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

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HOME CARE AND REHABILITATION SERVICES	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Home Health and Hospice Care Services <i>Home Health Services require pre-certification after initial evaluation; Hospice Care Services require 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
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
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>	\$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
	\$30 Non-Preferred Brand-Name co-payment	100% after co-payment	100% of charges	Not a covered benefit
Home Delivery 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
	\$60 Non-Preferred Brand-Name co-payment	100% after co-payment	100% of charges	Not a covered benefit

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Federal Mental Health Parity applies; Mental Health and Substance Abuse benefits are subject to change pending final interpretation and requirements of the Federal Mental Health Parity mandate.

Benefit Enhancement Rider

BlueCross BlueShield of Vermont believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-800-247-2583. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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.

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