Benefits of the

Vermont Education Health Initiative

vehi

path
PLANNED ACTION TOWARD HEALTH

VEHI's health benefit plans are administered by:

BlueCross BlueShield of Vermont

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

What is VEHI?

The Vermont Education Health Initiative (VEHI) is a member-owned, non-profit organization that serves Vermont school districts and the Vermont State Teachers' Retirement System (VSTRS) by offering high-quality, affordable health plans responsive to the needs of employers, local unions, and employees and their dependents.

VEHI's health program has been operating for more than two decades. It is managed jointly by the Vermont School Boards Insurance Trust (VSBIT) and the Vermont-National Education Association (VT-NEA).

All funding for VEHI's health program comes from its members and is used to pay claims and costs associated with providing health benefits and wellness programs for school employees and retirees. Over 90 percent of all funding goes to pay actual claims; approximately 9 percent pays for BCBSVT administration of the program and state and federal taxes, assessments and fees. The remaining one percent funds VEHI's wellness program and administrative costs.

Dear school employees,

We are committed to providing a range of employee benefit plans that are cost-effective, affordable and high quality. Our program invests in school-based and post-employment wellness programs that give you and your families the confidence, support and resources they need to lead healthy, productive lives. We are also intent on keeping school districts, local unions and VSTRS informed about the health care market, health care reform initiatives and regulatory compliance under federal and state law.

We urge you to consider yourself a purchaser of health care rather than a beneficiary of insurance. We believe involving you directly in the purchasing of health care services provides the necessary link between providers and consumers that can ensure high-quality products and services at affordable and sustainable prices. Vermont schools, taxpayers, VSTRS and school employees, active and retired, all benefit from the smart use of health care dollars.

Please don't hesitate to contact us with any questions or concerns.

Sincerely,

Laura Soares
PRESIDENT OF VEHI/VSBIT
AND CO-TRUST ADMINISTRATOR OF VEHI

Mark Hage
VERMONT–NEA DIRECTOR OF MEMBER BENEFITS PROGRAMS
AND CO-TRUST ADMINISTRATOR OF VEHI

About this booklet

This booklet contains information about health benefit plans for active employees (who meet eligibility standards on page 6) and is intended to help you make an educated choice regarding which health care plan suits you best. Plan descriptions and information begin on page 23. This booklet summarizes the benefits and requirements of the plans offered, helps you understand your plan, choose the best plan for you and your dependents and make the most of your plan. For full information, you must consult your Summary of Benefits and Coverage (SBC) and a sample Benefits Description at **vehi.org.**

Once you enroll, you can access the plan documents on BCBSVT's member resource center or call BCBSVT's customer service team to request hard copies sent by mail.

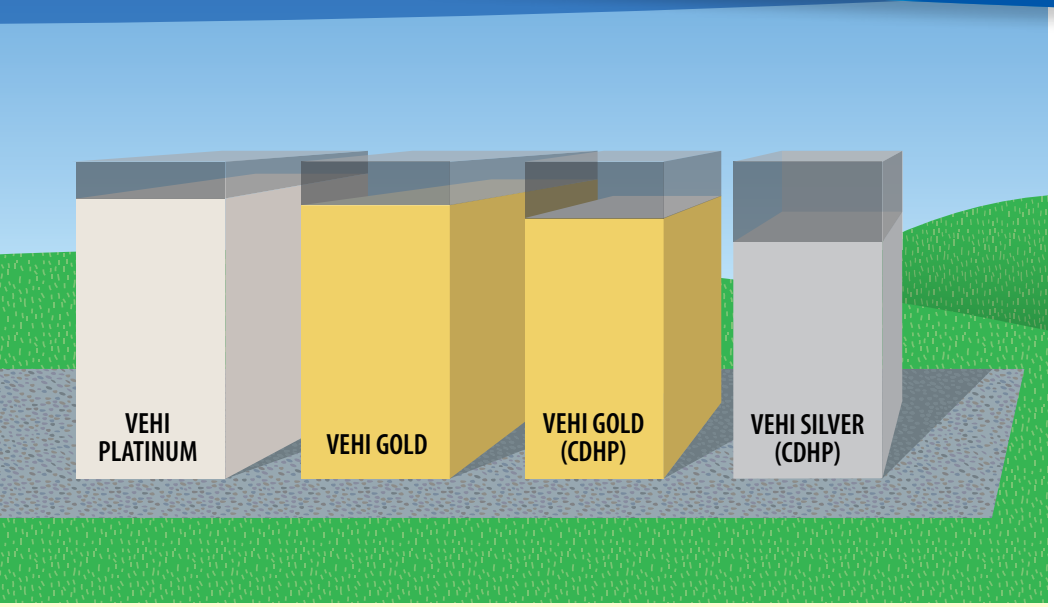
Your plan documents consist of your:

- Benefits Description
- Benefits Description Wrap Document; and
- Outline of Coverage

In the event of any discrepancies between this document and your plan documents, your plan documents prevail.

Blue Cross and Blue Shield of Vermont provides administrative services and does not assume any financial risk for claims.

VEHI coverage



VEHI's four health plans:

- **VEHI Platinum**—see page 25
- **VEHI Gold**—see page 27
- **VEHI Gold CDHP** —see page 31
- **VEHI Silver CDHP**—see page 33

All variations occur in the plans' payment terms and cost-sharing—each offers different member out-of-pocket arrangements.

Schools must offer all four health plans to all employees.

VEHI plans have:

- Comprehensive medical coverage in every major benefit category
- A range of cost-sharing options (see the comparison on page 23)
- A calendar-year deductible and cost-sharing (that restarts on January 1)
- The largest, most extensive network of providers within Vermont and the U.S., with over 96 percent of hospitals and 92 percent of health care providers in the U.S. (the percentage is even higher in Vermont)
- The freedom to choose providers from the nationwide EPO/PPO Network without a referral
- For all plans, you will choose a **primary care provider (PCP)** for each family member, but you don't need referrals to see in-network specialists. If you or your dependents live outside of BCBSVT's Network area, you are not required to select a PCP
- Access to doctors and hospitals in more than 200 countries and territories around the world through the BlueCard Worldwide® Program
- The security of the Blue Cross and Blue Shield ID card—the most recognized symbol in health benefits worldwide
    - Award-winning, Blue Cross and Blue Shield of Vermont customer service staff available Monday through Friday, 7 a.m. to 6 p.m., and 24-hour, seven-day-a-week access via BCBSVT's website

- State-of-the-art wellness programming offered by VEHI PATH and BCBSVT, featuring online tools, face-to-face discussions and much more (**www.vehi.org**).
- Preventive care, rated A and B by the United States Preventive Services Task Force (USPSTF), at no cost to you .
- The Blue HealthSolutions℠ program, including health management features such as Better Beginnings®, chronic condition management and an expansive health information website.
- A parent/child tier that will cost less than a two-person (two adults) or family plan. A parent can cover any number of children on the plan at no extra cost.
- VEHI's Platinum and Gold plans offers a four-tier drug system. For more details on this and other pharmacy changes, see page 18.
- CDHPs offer a wellness drug benefit, which provides coverage for certain drugs that can help you maintain your health, with no cost to you.
- 24/7 access to telemedicine providers through **Amwell.com** for general consultative services such as
  - colds and flu
  - sinus, ear and eye infection
  - headaches; and
  - allergies.

Membership information

Eligibility

You must be an active employee to be eligible for enrollment, you must be an employee of the same district/supervisory union and work a minimum of 17.5 hours per week for the same district/ supervisory union during the school year. Hours worked are not to be aggregated across districts or supervisory unions to meet this requirement.

Open enrollment/changing plans

Federal rules require open enrollment periods align with an employer's Section 125 (Cafeteria) plan year.

Your employer is limited to just one annual open enrollment period (generally January or July) during which time you may:

- enroll yourself and your eligible dependents in plan coverage if you previously waived coverage;
- add or remove dependents from coverage for any reason;
- change health plan options.

If BCBSVT receives your request before this date, they will make the change effective on the open enrollment date. If BCBSVT receives your request during the month in which your open enrollment occurs, they will make the change effective on the first of the following month.

This is the only time you can make these changes unless you and/or your eligible dependents experience a change in life status (for example, a birth or loss of coverage). For more information regarding change-in-status events, inquire with your school district.

BCBSVT also advises you to contact your school district to determine when your group's open enrollment period takes place. If you have questions about membership please contact your group benefits manager.

Please note any membership changes must align with your school district's Section 125 plan rules.

Please note that for purposes of enrollment "days" refers to calendar days.

Marriage

If BCBSVT receives your request within 31 days after the date of marriage, your new type of membership begins the first day of the month following the date of marriage. If BCBSVT receives your request more than 32 days after the date of your marriage, your new membership begins the first day of the month after BCBSVT receives your request.

If you fail to add your new Dependents within 60 days, you must wait until your next open enrollment date.

Birth or adoption

The Plan Covers your Child for 60 days after:

- birth;
- legal placement for adoption (if it occurs prior to adoption finalization); or
- legal adoption (when placement occurs when the adoption finalizes).

BCBSVT must receive your request for adding a dependent Child to continue benefits for the Child past 60 days. If BCBSVT receives your request within the 60 days:

- the Child's effective date is retroactive to the date of birth, placement for adoption or adoption; and
- the new type of membership begins 60 days following birth, placement for adoption or adoption.

If you fail to add your new Dependents (child or children) within 60 days, you must wait until your next open enrollment date.

Dependent's Loss of Coverage

Any Dependents Covered under another health plan are eligible for coverage under the Plan if the Dependent loses his or her Group health coverage or ends employment. Within 31 days after loss of coverage, your Dependent may enroll on your current Plan, or you and your Dependents may change to any other Plan your employer offers. If you fail to add your Dependent within 31 days after loss of coverage, you must wait until an open enrollment date.

Court-ordered dependents

In the case of an order issued in compliance with your state laws child medical support order law, the effective date will be three days after you mail the court order to BCBSVT or when BCBSVT receives the court order, whichever is sooner. If the court order specifies a different effective date, BCBSVT will use that date. BCBSVT will calculate any additional premiums from the effective date of enrollment. Please remember your request for Dependent coverage under any court order must include proof of the court order.

Special enrollment rights under "CHIP"

The "Children's Health Insurance Program Reauthorization Act of 2009" ("CHIP") requires group health plans to offer special 60-day enrollment periods to employees and their dependents who are not covered by the group plan and then lose eligibility for Medicaid or Dr. Dynasaur.

You must request coverage no later than 60 days after losing coverage from Medicaid or Dr. Dynasaur. You may choose either the date coverage ends or the first of the month following BCBSVT's receipt of a valid enrollment request as the effective date for coverage under your group health plan.

You (and/or any dependent) must submit proof that you are eligible to enroll because one of the events above has occurred.

You may experience other special enrollment events. Please contact your employer with any questions or concerns regarding your or your dependent's eligibility.

Finding a doctor

Finding a BCBSVT network provider

BCBSVT has an expansive provider network throughout Vermont and many contiguous counties. And finding a network provider is easy. The most up-to-date information about BCBSVT's provider network appears online.

To find out if a provider is in BCBSVT's network:

- Visit **www.bcbsvt.com/findadoctor**
- To find a provider or hospital in Vermont or the surrounding area, select "providers and Hospitals in Vermont Service Area."
- You may search by name or by provider type.
- In the drop-down box marked "Network," select "BCBSVT Network Providers."
- Scroll down the page to refine your search. You can search within a specific distance, for example, or look for providers of a certain gender or those who speak a language other than English.

After your search results appear, find the printer icon and select "Print Search Results Directory" to create a printer-friendly file you can print or save to your computer.

Although you receive services at a network facility, the individual providers may not be network providers. Please make every effort to check the status of all providers prior to treatment.

As of this printing, BCBSVT's Vermont network of providers includes more than 95 percent of the providers in the state and all of Vermont's hospitals. BCBSVT's pharmacy network includes nearly every Vermont pharmacy.

Finding national providers and providers around the globe

Use the National Provider Hospital Finder to find national providers, hospitals and other providers in your plan's network. We encourage you to use this tool, rather than relying on out-of-state providers to advise you of whether or not they are in the network.

To use the tool, go to: **provider.bcbs.com**

- Type in the first three letters (your alpha prefix) that appear in front of your member number on your ID card
- VEHI's alpha prefix is **VEI**.
- This three-digit alpha prefix signifies what your provider network is. You must use the **Blue Card PPO/EPO network**.
- Although you receive services at a network facility, the individual providers may not be network providers. Please make every effort to check the status of all providers prior to treatment.

If you have questions, you may call BCBSVT's customer service team at the number on the back of your ID card or **(800) 810-BLUE (2583).**

We can also send you a paper provider directory before you leave the area, if you wish. Both electronic and paper directories give you information on provider qualifications, such as training and board certification.

Selecting a primary care provider (PCP)

You must select a primary care provider for each covered family member in order to enroll. To do this:

- Follow the steps above to find a doctor online and check the PCP box in the "Role/Specialty" section.
- If you are not currently seeing a primary care provider, be sure to check the "Accepting New Patients" box at the bottom of the form.
- If you are currently seeing a primary care provider, he or she may not be taking new patients. Be sure to check the "Existing patient" box on your enrollment form when you enroll.
- Use the provider name and National Provider Identification (NPI) number from your search results to complete your enrollment form.

Please note if you or your dependents live outside of BCBSVT's Network area, you are not required to select a PCP.

Understanding your networks	
PCP required	Yes, but you do not need a referral to see a specialist.
Network care	You may use our BCBSVT Network providers in Vermont and contiguous counties, as well as our national PPO/ EPO Blue Card Network.
Non-network care	You must get prior approval for all non-network care. Non-network care is care you receive from a provider that does not contract with BCBSVT, or with any Blue plans, and is not in the local BCBSVT network or the national Blue Card EPO/PPO network.
Emergency or urgent care	You do not need to see a network provider for emergency or urgent care services (as defined in your Benefits Description). In these situations, please seek care immediately. If a non-network provider balance bills you for emergency or urgent care services, please call BCBSVT's customer service team at the number listed on the back of your ID card.
Finding a Local Vermont provider	To find a BCBSVT provider visit **www.bcbsvt.com/ findadoctor** or call the number listed on the back of your ID card.
Finding a National Blue Card provider	To find a Blue Card provider 24 hours a day, seven days a week, please visit **provider.bcbs.com** or call **(800) 810-BLUE (2583)**.

Web resources

VEHI's Web resources

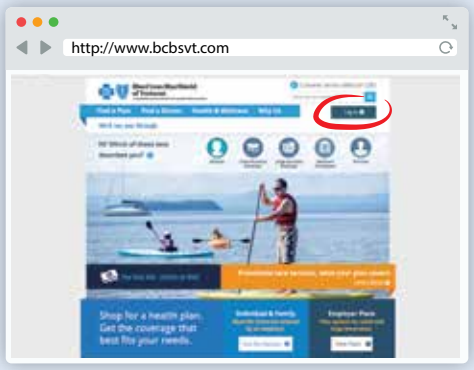
Visit **vehi.org** for the latest news and important developments regarding your plan. You can also find links to better understand your benefits, compliance resources, our wellness program and how to contact us.

For more information about VEHI's wellness program, PATH, please see page 36.

BCBSVT's secure member site

From BCBSVT's home page, you may log into the secure Member Site, where you can:

- check claims status
- track your out-of-pocket costs
- look up your health plan benefits
- check how many visit limits you have left in a calendar year for certain services such as chiropractic care or PT/OT/ST
- use secure e-mail to ask questions and hear back within 24 hours
- use Healthcare Advisor to compare cost and quality data on a variety of providers, services and supplies
- order ID cards
- file a change of address



To gain entry to the member site, visit **www.bcbsvt.com/member** and click on Member Login.

- You will need your member identification card to register.
- You must enter your information in a specific format.
- You will enter your ID number without the three-letter prefix and your two-digit member number.
- The member resource center includes a graphic that will show you where to find these numbers on your ID card.

Preventive care

Blue Cross and Blue Shield of Vermont (BCBSVT) and VEHI want you to get preventive care so you can find out about health problems early and get the treatment you need. Some preventive care can keep you from becoming sick in the first place. This section explains which preventive care is right for you and how the plan covers various services.

***For a more detailed description of preventive care, including charts that list care rated A or B by the USPSTF, visit www.bcbsvt.com/preventive**

What is preventive care?

Preventive care includes screenings, tests, medicines and counseling performed or prescribed by your doctor or other health care provider when you don't have signs or symptoms of an injury or illness. Your provider delivers some care to prevent you from getting sick. Other preventive care helps detect health conditions early, so you can change your lifestyle or get treatment to improve your health. We encourage you to get appropriate preventive care for your age and gender.

What will preventive care cost me?

VEHI covers certain preventive services at no cost to you (i.e., with no "cost-sharing," like deductibles, co-insurance or co-payments). We provide this benefit for all services rated A or B* by the United States Preventive Services Task Force (USPSTF), a board of physicians who have researched preventive services to determine which are the most effective. We also cover certain women's health services, vaccines, care for children without cost-sharing.

What is the difference between preventive and diagnostic medicine?

A preventive procedure starts with the intent of confirming your good health when you are seemingly free of symptoms or disease. Diagnostic medicine happens when you go to your doctor or other health care provider with symptoms and your provider recommends screenings and tests to diagnose their cause. While we cover diagnostic services, you may have to pay deductible and co-insurance, or co-payments.

Can preventive care turn into diagnostic medicine?

Yes. Sometimes a provider begins a preventive screening or test and, during its course, finds or suspects disease. The provider then bills for a diagnostic procedure. You may have to share in the cost. Also, if you have a history of a particular illness, a screening related to that illness might be considered diagnostic for you, while it may be preventive for other patients.

Check out these examples:

Scenario 1: A 30-year-old woman without symptoms has an annual physical. It includes a breast exam, a Pap smear, cholesterol and glucose screening and screening for sexually transmitted diseases. The Pap smear shows an irregularity. The first exam will be paid at the preventive level. A follow-up exam, done at a later date because of the irregularity of the Pap, will be paid subject to cost-sharing.

Scenario 2: You have a lipid test and a metabolic panel (a blood test that measures your glucose level, electrolyte and fluid balance and kidney and liver function) at your annual physical. You do not have cost-sharing for the lipid test, but since the metabolic panel does not appear on the USPSTF's list of A- and B-rated services, you must share in the cost of the metabolic test.

Are there other preventive services that I may need?

Yes, you may need other preventive services because of your individual health care needs. The USPSTF bases its recommendations on the needs of the general population. You may have special needs, so we encourage you to consult your doctor or other health care provider about additional preventive care. You may have cost-sharing if you have such services.

Preventive medications *(available at no cost; requires prescription)*

Service	*Examples/restrictions*
Aspirin	Men, ages 45–79, and women, ages 55–79 (generic only)
Breast cancer prevention	Women, no age restrictions
Contraception	Women, no age restrictions (generic only for oral contraceptive medications)
Vitamin D supplements	Adults age 65 and over
Folic acid supplements	Women, ages 12–50
Fluoride supplements	Children, ages 6 mos.–5 years (generic only)
Pediatric iron supplements	Children, ages 6 mos.–12 mos. (generic only)
Smoking cessation	Up to 180-day supply of nicotine replacement therapies
Folic acid supplements	Women, ages 12–50
Statins	Adults ages 40-75 without a history of cardiovascular disease (generic only)

Maternity coverage

Understanding your maternity coverage

Your plan covers OB-GYN office visits and childbirth and delivery services. Members enrolled in our Better Beginnings program receive extra benefits. If you're interested in learning more about BCBSVT's Better Beginning Program, see page 34 for details or call (800) 922-8778.

Blue Cross and Blue Shield of Vermont's customer service team can also help you plan for the arrival of your new baby and understand your cost-sharing responsibilities. Please call the number listed on the back of your ID card for more details.

For maternity care on the Platinum and Gold plans, a $25 co-payment applies to the first office visit to confirm pregnancy. After confirmation of pregnancy, all routine provider fees for pre-natal and postnatal care, management of labor and delivery, and other care related to your pregnancy are covered by one additional $25 co-payment. In most cases, when using one network provider, you may not be billed any co-payments for routine pre-natal visits, postnatal visits, or professional fees related to delivery until after you deliver your baby. Other services and tests are subject to deductible and co-insurance, including hospital-related delivery charges. You won't pay co-payments, deductible and co-insurance for preventive maternity care defined under the Affordable Care Act. (***See below for details regarding no-cost preventive care during and after pregnancy***.)

For maternity care on the Gold CDHP and Silver CDHP, deductible and co-insurance apply to the first office visit to confirm pregnancy. After confirmation of pregnancy, all routine provider fees for pre-natal and postnatal care, management of labor and delivery, and other care related to your pregnancy will be subject to your deductible and co-insurance up to your medical out-of-pocket limit. After this office visit, however, when using one network provider, you generally won't be billed deductible and co-insurance for routine pre-natal visits, postnatal visits, or professional fees related to delivery until after you deliver your baby. Other services and tests are subject to deductible and co-insurance, including hospital-related delivery charges. You won't pay deductible and co-insurance for preventive maternity care as defined under the Affordable Care Act. (***See below for details regarding no-cost preventive care during and after pregnancy.***)

For all VEHI plans, you should expect to meet your medical out-of-pocket limit.

Preventive care during and after pregnancy

The table on the left is a reference guide of preventive care screenings that should be factored into your usual preventive care screenings, exams and medicines. This additional care may require cost-sharing.

Federal and state regulators recommend certain screenings for pregnant women. If you have questions at any point, consult your provider or call the number listed on the back of your ID card.

Blue indicates that every woman should have this screening, exam or medicine. We cover it without cost-sharing.

Green indicates that there are unique circumstances that may be covered by BCBSVT with no cost-sharing if you qualify. Consult your doctor to see if this screening, exam or medicine is right for you.

Preventive care guidelines			
Infectious disease	Asymptomatic Bacteriuria	Screening recommended at 12-16 weeks gestation or at first prenatal visit, if later.	No cost to you
	Chlamydial infection	Screening recommended at first prenatal visit for all pregnant women aged 24 or younger and for older pregnant women who are at increased risk.	
	Gonorrhea	Screening recommended at first prenatal visit for all sexually active, pregnant women.	
	Hepatitis B Virus	Screening strongly recommended at first prenatal visit.	
	Syphilis infection	Screening recommended at first prenatal visit.	
Obstetric conditions	Rh (D) incompatibility	Blood typing and antibody testing strongly recommended at first prenatal visit.	
Breastfeeding	Support and counseling		
	Supplies	You must get Prior Approval for hospital-grade breast pumps	
Other screenings	Alcohol and drug misuse		
	Depression		
	Smoking cessation		
	Gestational diabetes		

Diabetic coverage

Understanding your diabetic treatment coverage

Your plan covers diabetic medication, supplies and durable medical equipment. Please note if you're planning on enrolling in a CDHP, we encourage you to obtain your testing supplies through your pharmacy benefits, which are covered at 100 percent of the allowed amount. You may also obtain many of these supplies through a Durable Medical Equipment supplier but they are subject to your deductible and co-insurance if you are on a CDHP.

	VEHI Platinum	*VEHI Gold*	*VEHI Gold CDHP*	*VEHI Silver CDHP*
Diabetic **medications** obtained through the **pharmacy** (includes medication found on the wellness drug list) such as **insulin**.	Covered at 100 percent	Covered at 100 percent	Covered at 100 percent	Covered at 100 percent
Diabetic **testing supplies** obtained through the **pharmacy** Examples include: ▪ **test strips** ▪ **syringes** ▪ **glucometer** ▪ **lancets**	Covered at 100 percent	Covered at 100 percent	Covered at 100 percent	Covered at 100 percent
Diabetic **medical equipment** and **pump supplies** obtained through a **durable medical equipment supplier** Examples include: ▪ **pump** ▪ **continuous glucose monitor** ▪ **infusion sets** ▪ **reservoirs**	Covered at 100 percent	Covered at 100 percent	Deductible, then co-insurance	Deductible, then co-insurance

Emergency and urgent care

Knowing when and where to get the most appropriate care is important. If possible, you should always try to arrange a visit with your primary care provider (PCP) first. Your PCP has the best overall picture of your health and can help you make informed decisions regarding your care.

There may be times when you cannot see your PCP, whether it's after regularly scheduled hours, or in the event your PCP cannot see you as soon as is necessary. Using an urgent care facility, when appropriate, can help you save lengthy hours spent waiting in the emergency room for care and lower your health care costs.

Make sure your favorite urgent care center is part of the BCBSVT Network or the national Blue Card PPO/EPO network

For a detailed list of urgent care facilities, please visit **www.bcbsvt.com/findadoctor**. Keep this information on hand by saving the urgent care facility's address and contact information in your phone or display it on your fridge.

	VEHI Platinum	*VEHI Gold*	*VEHI Gold CDHP*	*VEHI Silver CDHP*
Urgent care	$75	deductible, then 20 percent co-insurance	deductible, then 20 percent co-insurance	deductible, then 20 percent co-insurance
Emergency room	$250	deductible, then 20 percent co-insurance	deductible, then 20 percent co-insurance	deductible, then 20 percent co-insurance

What is an urgent medical condition?

Urgent care service are services that are necessary to treat a condition or illness that if not treated within 24 hours presents a serious risk of harm, or, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the ability of the individual to regain maximum function. Or, in the opinion of a Provider with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without care within 24 hours.

Please note :the Plan Covers Urgent Services received at an urgent care facility. You may be balanced billed for services obtained outside of the Network. If you are balanced billed, please call customer service at the number listed on the back of your ID card.

When to seek out urgent care services at an urgent care facility?

If your condition is not life threatening, but needs attention, an urgent care facility may be the most appropriate option. Urgent care facilities are located throughout Vermont and offer many of the same services your PCP offers. Most urgent care facilities have regularly scheduled hours.

What is an emergency medical condition?

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- a condition that places the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

In the case of an emergency—seek care right away!

If you experience an emergency medical condition that places your health, or the health of an unborn child or dependent, in serious jeopardy, seek care immediately. Emergency rooms are open 24 hours a day, seven days a week and offer a wide range of services.

Undoubtedly, there may come a time when seeking emergency care is required. But, in many cases, people go to the emergency room for urgent services that are better treated by an urgent care facility, your PCP or a telemedicine visit.

Seeking care in the least restrictive, most appropriate manner is important, but so too is educating yourself on the difference between urgent care and emergency care.

KNOW BEFORE YOU GO

Make the right care choice.

Be informed now so that you can choose the appropriate care for your situation. Understanding all your options may save you time and money.*

Get more information!
Go to: **www.bcbsvt.com/knowbeforeyougo**

BlueCross BlueShield of Vermont

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

We'll see you through.

Primary care provider

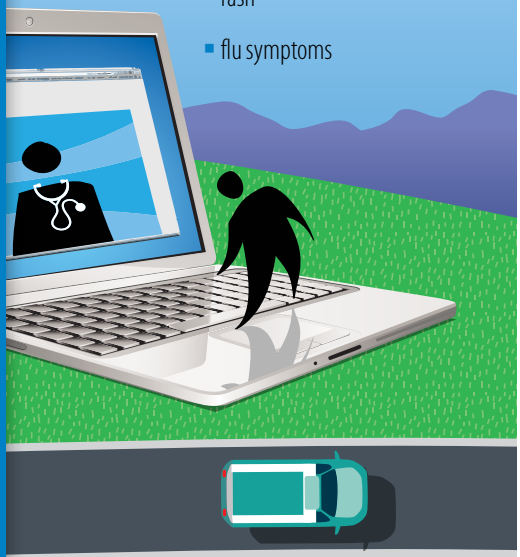
You should contact your regular provider for most urgent care and common health issues during office hours. Some examples are:

- infections
- cough
- digestive issues

Telemedicine

You can access a clinician remotely for diagnosis and treatment via phone, video or other technologies. Commonly treated conditions:

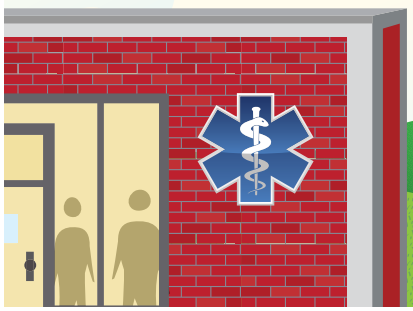
- pink eye
- rash
- flu symptoms



Urgent care center

When you have a condition or illness that is not an emergency, but still needs quick attention, you could seek urgent care services. Urgent care could include treatment for:

- minor cuts
- minor back pain
- broken bones



Emergency room

In an emergency, you need care right away. Emergencies might include:

- chest pains
- head injury with fainting
- injury to spine

If you have an emergency at home or away, call 9-1-1 or go to the nearest doctor or emergency department. You should call an ambulance if necessary.

*Prior approval requirements and member benefits vary according to the member's group or individual plan. Before receiving services, please check your benefits as outlined in your member materials or by calling the number on the back of your ID card.

Telemedicine program

Sick on a weekend? Trying to get help with a rash between work meetings? Worried about a feverish baby in the middle of the night? Advice from a leading doctor is as close as your computer, tablet or smart phone. Blue Cross and Blue Shield of Vermont (BCBSVT) offers telemedicine services with Amwell, a nationally acclaimed telemedicine vendor, to provide you with services 24/7, wherever you are.

Telemedicine is an online video consultation with a doctor via a computer or an app on a smartphone or tablet. Doctors can help you with basic acute care issues like:

Providers can also prescribe medication, if needed. (Please note distribution of prescriptions are subject to state law.)

- respiratory infections
- bronchitis
- urinary tract infections
- pharyngitis
- rashes
- pink eye
- cough
- flu
- stuffy head
- allergies

Helpful tips!

1. **Register before you get sick!**

This way, when illness hits, you are merely a finger tap away from getting the care you need. Visit **Amwell.com** to register or download the Amwell app from the iTunes or Google Play store. If you have any questions about how the service works, please feel free to contact Amwell at (855) 818-3627.

2. **After any telemedicine visit, follow up with your primary care provider's office.**

Keeping your primary care provider informed helps your provider manager your health and overall wellness and any follow-up care you may need.

3. **Keep a list of important health care numbers on your fridge or family cork board.**

It's a good idea to keep a list of important contact information such as how to access telemedicine services, the number for your closest urgent care facility and your primary care provider's office number on hand. When you're not feeling well, having these numbers handy helps save time and energy. In the case of an emergency seek care right away by dialing 9-1-1.

Cost-sharing for telemedicine services

Please note: a medical consultation via Amwell requires cost-sharing.

How to download the app for your smartphone or tablet

Follow these steps to connect with Amwell through the app:

- Grab your BCBSVT ID card and have a medical history nearby, as you'll need certain information in order to use Amwell.
- Search for and download the Amwell app from the Apple App Store (if you have an Apple Device) or from the Google Play Store (if you have an Android device)
- Install the app—you open the app by finding an icon on your device that looks like a heart with a checkmark in it.
- Open the app and register for your virtual visit in order to access benefits through your health plan (self-pay options are also available through Amwell).
- Select BCBSVT from the drop-down menu in the health plan field when prompted.
- Select "Medical" when prompted to choose the type of service you want. (While Amwell offers mental health and substance abuse services, BCBSVT does not currently contract with the company for that type of service.)
- Next, you'll see a list of doctors available to you. Select the doctor you'd like to see. (Please note that while the doctors might be located anywhere, the ones available to you will be licensed in the state of Vermont.)
- You will next need to answer some questions about the problem for which you're seeking care and some general information about your health status and history.
- That's it! You'll next watch a short Amwell welcome video and go to the virtual "waiting room" for your provider.
- If you can't wait, you can also schedule an appointment for a time that is convenient for you.

The online app will contain many features to make your visit more effective. Find icons for the following on the bottom of your screen:

- Adjust your settings.
- Take photos and send them to your doctor.
- Adjust the volume or mute the microphone on your device.
- Receive a post-visit report about your visit that you can share with your PCP.

You can also connect via the internet on your computer!

Please visit **amwell.com** and follow these easy steps.

- Grab your BCBSVT ID card and have a medical history nearby, as you'll need certain information in order to use Amwell.
- Register for your virtual visit in order to access benefits through your health plan (self-pay options are also available through Amwell).
- Select BCBSVT from the drop-down menu in the health plan field when prompted.
- Select "Medical" when prompted to choose the type of service you want. (While Amwell offers mental health and substance abuse services, BCBSVT does not currently contract with the company for that type of service.)
- Next, you'll see a list of doctors available to you. Select the doctor you'd like to see. (Please note that while the doctors might be located anywhere, the ones available to you will be licensed in the state of Vermont.)
- You will next need to answer some questions about the problem for which you're seeking care and some general information about your health status and history.
- That's it! You'll next watch a short Amwell welcome video and go to the virtual "waiting room" for your provider.
- If you can't wait, you can also schedule an appointment for a time that is convenient for you.

Prefer a phone call? Or, are you unable to connect via computer or smartphone? Call Amwell directly!

Amwell doctors are also available by phone at (844) 733-3627. Please note, however, that by state law in Vermont (and most other states), doctors may not write prescriptions to patients with whom they consult by phone. More services will be available to you if you meet with a doctor by video using the convenient Amwell app.

Pharmacy programs

As a VEHI member, you will get your prescription drugs through BCBSVT's network of pharmacies, here in Vermont and nationwide. Present your Blue Cross and Blue Shield of Vermont ID card at a network pharmacy and the pharmacist will file a claim for you.

Prescription drug prices are a leading cause of increases in health care costs and VEHI's health plan premiums. One way to reduce medication costs substantially is to use generic drugs whenever possible. Generics are less expensive than brand-name medications and are just as medically effective.

Almost all Vermont pharmacies and a large percentage of pharmacies nationwide currently belong to this network. Most major chains (Rite-Aid, Kinney, CVS, etc.) participate. Call (877) 493-1949 or visit the Find-a-Doctor page of BCBSVT's website for a list of network pharmacies.

VEHI Platinum and Gold Drug Coverage:

To understand what you will pay if you choose the VEHI Gold or Platinum plan, please see the charts starting on page 25.

VEHI is among the first of BCBSVT groups to offer the cost-saving "4-tier" drug program. This drug program applies to the VEHI Platinum plan and the VEHI Gold plan, but not to the CDHP plans.

Please note that the 4-tier drug program will continue to cover medicines for diabetes at 100 percent. For more information regarding diabetic supplies and medications, please see page 13.

VEHI Gold and Silver CDHP Drug Coverage

To understand what you will pay if you choose the VEHI Gold CDHP or Silver CDHP, please see the charts starting on page 31. CDHP members will pay deductibles and co-insurance for most drug coverage to comply with federal guidelines.

To be sure that members get the important wellness drugs they need, VEHI will offer its CDHP members coverage (at no cost) on certain drugs that can prevent illness or keep chronic conditions from becoming more serious. For example, VEHI offers no-cost coverage on prenatal vitamins and many drugs that treat:

- diabetes (medications and testing supplies)
- high blood pressure
- high cholesterol
- asthma
- osteoporosis

The "wellness drug list" changes from time to time. The most recent copy appears on the Rx Center of the BCBSVT website at **www.bcbsvt.com/wellnessrx**.

For all plans

To align more closely with benefit products typically on the market, VEHI has eliminated coverage of drugs designed to treat sexual dysfunction and infertility. Please note that services to determine a couple's infertility will still be covered. Also, if you are taking infertility medication prior to January 1, 2018, VEHI will cover the end of your course of treatment under your previous terms of coverage.

If you are prescribed a maintenance drug for the first time, you may only obtain a 30-day supply. If this medication works for you, at your second fill, you may be eligible for up to a 90-day supply. For more details regarding your maintenance prescription drug coverage, please contact BCBSVT's customer service team at the number on the back of your ID card.

Drug list updates

Drug lists change and will be updated periodically to ensure that newer, more effective drugs are added.

Drugs automatically come off the preferred brand-name drug list and are added to the generic lists when alternatives become available. You may reduce your out-of-pocket expenses by asking your provider to authorize a generic solution whenever possible. The use of generics guarantees you the lowest cost.

When a generic is not available, ask your provider if one of the drugs on the preferred brand-name drug list would be appropriate for you. These drugs can often meet patients' needs at a lower cost. A list of preferred brand-name drugs is available at the Rx Center of BCBSVT's website, **www.bcbsvt.com/pharmacy/drug-lists**.

Convenient refills and savings with BCBSVT's home delivery program

If you use prescription drugs on an ongoing basis, BCBSVT's home delivery service may be a less expensive, more convenient way for you to buy prescriptions. To begin using home delivery service for your maintenance drug, send BCBSVT's mail order pharmacy your doctor's prescription, an order form (available online or by phone) and any required cost-sharing amounts. For cost-sharing details, please see the charts starting on page 23.

To request refills, you may use a online ordering system, **www.express-scripts.com**, or call the toll-free number, (877) 493-1949. (Narcotics and antibiotics are not available through the home delivery service.)

Over-the-counter drugs

The plan covers certain over-the-counter drugs if you have a prescription from your provider. For example, the plan covers drugs like Claritin for allergies or Prilosec for stomach acid and reflux.

With a prescription, your pharmacist can dispense up to a 30-day supply of the medication and charge you the same amount you would pay for generic drugs. For cost -sharing details, please see the charts starting on page 23.

BCBSVT's review of certain drug classes keeps costs down for you

Prior approval

BCBSVT's prior approval list changes periodically. The most current list can be found on the BCBSVT website or by calling toll-free (877) 493-1949. Prior approval is required for drugs that have been on the market less than 12 months and/or medications without National Drug Code numbers. For example:

- Chemotherapeutics
- Growth hormone replacement therapy
- Hepatitis C medications
- Low molecular weight heparin anticoagulants (for use in excess of 30 days per calendar year)
- Primary pulmonary hypertension therapy
- Biologics and other medications
- Brand-name drugs with generic equivalents

A complete list of drugs that require prior approval is available at the Rx Center of BCBSVT's website, **www.bcbsvt.com/pharmacy.**

Quantity limits

If your doctor prescribes a drug in an amount that exceeds certain criteria, such as the manufacturer's recommendations, BCBSVT may ask for documentation. Visit BCBSVT's website at **www.bcbsvt.com/pharmacy** or call toll-free (877) 493-1949 to get a current list of drugs covered by this review or to learn the quantity limit for a particular drug. At present, BCBSVT places quantity limits on the following types of drugs:

- Sleeping agents (such as Ambien®)
- Glucose test strips
- Inhalers (like Advair®)
- Pain medications (like OxyContin®)
- Anti-migraine medications (like Imitrex®)

Step therapy

BCBSVT's step therapy program saves members money by encouraging patients and their doctors to try less expensive drugs in a therapeutic class before using the newest, most expensive ones. Step therapy applies to drugs in categories such as:

- Certain anti-migraine agents (like Zomig®)
- Certain medications for depression (like Prozac Weekly®)
- Non-sedating antihistamines (like Allegra®)
- COX-2 inhibitors (like Celebrex®)
- Medications for stomach acid (like Nexium®)
- Medications for hypertension (like Cozaar®)
- Anti-viral medications
- Sleeping agents (like Lunesta®)
- Statins (cholesterol-lowering drugs)
- Nasal steroids (like Nasacort®AQ)
- Osteoporosis agents (like Boniva®)

Visit BCBSVT's website at **www.bcbsvt.com/pharmacy** or call toll-free (877) 493-1949 to get a current list of drugs covered by this review or to learn the procedures to follow for review of your prescription use.

Prior approval program

BCBSVT's prior approval program

To keep costs down and to help you get care in the most convenient and cost-effective settings, BCBSVT's staff of nurses, clinicians and doctors may work with you or your provider through the prior approval program.

You must get prior approval for out-of-network care. The plan also requires prior approval for certain services and drugs even when you use network providers.

- Network providers get prior approval for you.
- If you see an out-of-network provider you must get prior approval before seeking care. Any provider may help you fill out the form and give you other information you need to submit your request. If you do not receive prior approval for out-of-network care, your plan will not cover your benefits.
- The plan does not require prior approval for emergency or urgent medical services regardless of where you seek care.
- Please note that certain drugs also require prior approval.
- BCBSVT lists the services that require prior approval in your Benefits Description, but this list can change from time to time.
- For the most recent prior approval list, visit **www.bcbsvt.com/priorapproval.com** or call the customer service number on the back of your BCBSVT ID card.
- The services on the next page require prior approval regardless of the provider you choose.

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General policy exclusions

You can be confident that your health plan covers a broad array of necessary services and supplies as described in this booklet. The following points highlight some of the services that your health plan does not cover:

- Services that are investigational, experimental, cosmetic or not medically necessary as defined in your Benefits Description.
- Services that should be covered by another source, such as another type of insurance or an employer.
- Non-medical charges like fees for completion of a claim form, personal service items or home modifications.
- Visual, dental, auditory or podiatric services, unless specifically provided by your Benefits Description.
- Providers who are not approved to provide a particular service or who don't meet the definition of "provider" in your Benefits Description.

If you would like to review your plan's complete list of General Exclusions before enrolling, visit **vehi.org** to view your sample Benefits Description. Once enrolled, you will have access to your specific Benefits Description, which details all General Exclusions on BCBSVT's Member Resource Center online. To learn more about BCBSVT's Member Resource Center, see page 9. (If you would like a hard copy, please call BCBSVT's customer service team at the number on the back of your ID card.) Please read your Benefits Description carefully; it is a part of your plan documents which govern your benefits.

Type of procedure	*What requires prior approval*
Ambulance	Non-emergency ambulance transport, including air or water transport
Anesthesia	Monitored
Autism	Treatment of autism spectrum disorder and intellectual disability
Capsule Endoscopy	All services
Chiropractic Care	Chiropractic care after initial 12 visits in a calendar year
Cochlear implants	Any aural rehabilitation devices
Chondrocyte Transplants	All services
Cosmetic Procedures	All services except breast reconstruction for patients with a diagnosis of breast cancer
Dental	All services
Durable Medical Equipment (DME)	With a purchase price of $500 or more
Electroconvulsive therapy (ECT)	All services
Gender reassignment	Services to treat gender dysphoria
Genetic Testing	Most tests—those with Health Care Procedure Coding System (HCPCS) Codes between S3800 and S3890
Hip resurfacing	All services
Hospital Beds	All supplies
Hyperbaric Oxygen Therapy	All services
Medical Nutrition for Inherited Metabolic Disease	Medical supplies and pumps, enteral formula and parenteral nutrition
New Medical Procedures	New procedures still considered investigational or experimental
Non-network services	All non-network services
Out-of-state Facility Care	All inpatient and partial inpatient care
Percutaneous radiofrequency ablation of liver	All services
Polysomnography (sleep studies) and Multiple Sleep Lateral Testing (MSLT)	All services
Prescription Drugs	Separate lists apply; please see Rx Center at **www.bcbsvt.com/rxcenter**
Prosthetics	With a purchase price of $500 or more
Psychological testing	All services
Radiation treatment	Such as high-dose electronic brachytherapy
Radiology Services	Certain services. Examples include CT, MRI, MRA, MRS, PET echocardiogram and nuclear cardiology..
Rehabilitation	Skilled nursing facility care, inpatient rehabilitation treatment for medical conditions, intensive outpatient services or residential treatment for mental health and substance abuse treatment
Surgery	Certain surgical procedures, including bariatric (obesity) surgery, gastric electrical stimulation, percutaneous vertebroplasty, vertebral augmentation, temporomandibular joint manipulation/surgery and anesthesia and tumor embolization.
Transcutaneous Electrical Nerve Stimulation (TENS) Units/Neuromuscular Stimulators	All units require approval
Transplants (except kidney)	All services
Wheelchairs	All supplies

Understanding general cost-sharing terms

VEHI's plans employ standardized cost-sharing arrangements such as co-payments, deductibles and co-insurance, medical out-of-pocket limits and prescription drug out-of-pocket limits to help you budget your costs.

This page explains the common cost-sharing terms. Not all terms listed below apply to all plans. For details regarding the plan-specific cost-sharing arrangements, please see the charts starting the next page.

What is a deductible?

A deductible is the amount you must pay towards the cost of applicable, covered services each calendar year. There are two kinds of deductibles— stacked deductibles and aggregate deductibles. See definitions at right.

What is an out-of-pocket limit?

An out-of-pocket limit is the maximum amount you must pay in a calendar year. You will have an out-of-pocket limit for both medical and prescription drugs regardless of the plan you choose. The out-of-pocket limit is made up of the co-payments, deductibles and co-insurance you pay per calendar year.

What is a co-payment?

A co-payment is a fixed dollar amount you must pay for applicable, covered services. Co-payments apply to your out-of-pocket limit.

What is co-insurance?

Co-insurance is a percentage of the allowed amount you must pay. For example, you will continue to pay co-insurance until you meet your medical out-of-pocket limit. For Prescription drugs (depending upon what play you choose), you may pay co-insurance for certain drugs until you meet your Prescription Drug out-of-pocket limit. See the chart on the right for details.

What is the allowed amount?

The allowed amount is the amount VEHI pays a contracted, network provider for a covered service. This amount is set based on competitive information, plan experience, provider feedback, employer group feedback and government reimbursement levels. Sometimes the total cost of a covered service is higher than the allowed amount.

If you see a network provider, this provider cannot bill you for the difference between the total cost of the service or supply and the allowed amount that VEHI must pay.

Stacked versus aggregate

If you are on a two-person, parent and child or family plan, paying attention to whether your plan is stacked or aggregate will help you budget your annual costs.

What is a stacked deductible?

If your VEHI plan has a stacked deductible, and you are on a two-person, parent and child or family plan, a covered family member may meet the individual deductible and begin receiving post-deductible benefits. When your family's expenses reach the family deductible, all family members receive post-deductible benefits.

What is an aggregate deductible?

If your VEHI plan has an aggregate deductible, and you are on a two-person, parent and child or family plan, you do not have an individual deductible.

Your family members' covered expenses must meet the family deductible amount before any of your family members receive post-deductible benefits. When your family's expenses reach this amount, all family members receive post-deductible benefits.

What is a stacked out-of-pocket limit?

If your VEHI plan has a stacked out-of-pocket limit, and you are on a two-person, parent and child or family plan, a covered family member may meet the individual out-of-pocket limit and VEHI will begin to pay 100 percent of the allowed amount for eligible services. Additionally, any combination of covered family members may meet the family out-of-pocket limit and VEHI will begin to pay 100 percent of the allowed amount for all family members' eligible services for the rest of the calendar year.

What is an aggregate out-of-pocket limit?

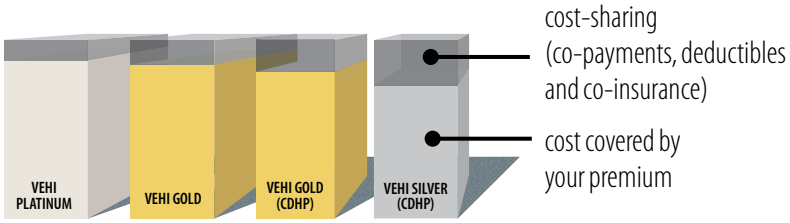
If your VEHI plan has an aggregate out-of-pocket limit and you're on a two-person, parent and child or family plan, you do not have an individual out-of-pocket limit.

Your family's expenses must meet the total family out-of-pocket limit before VEHI pays 100 percent of the allowed amount for eligible services. When your family's expenses reach this amount, all family members receive 100 percent coverage for the rest of the calendar year.

Watch for VEHI's online videos for a more detailed understanding of cost-sharing and VEHI plan details.

VEHI plan comparison

	VEHI PLATINUM	VEHI GOLD	VEHI GOLD CDHP*	VEHI SILVER CDHP*
Types of Services	***Deductible/Maximum***	***Deductible/Maximum***	***Deductible/Maximum***	***Deductible/Maximum***
medical deductible (individual/family)	$500 / $1,000 | stacked^	$1,200 / $2,400 | stacked^	$1,800 / $3,600 | aggregate**	$3,000 / $6,000 | stacked^
prescription drug deductible	$0	$0	included in medical	included in medical
medical out-of-pocket limit (individual/family)	$1,500 / $3,000^	$1,800 / $3,600^	$2,500 / $5,000**	$4,000 / $8,000^
prescription drug out-of-pocket limit (individual/family)	$1,300 / $2,600^	$1,300 / $2,600^	$1,350 / $2,700**	$1,350 / $2,700**
TOTAL out-of-pocket exposure for both medical and prescription drug benefits (individual/family)	$2,800 / $5,600	$3,100 / $6,200	$2,500 / $5,000	$4,000 / $8,000
Service Categories	***Co-payment/Co-insurance***	***Co-payment/Co-insurance***	***Co-payment/Co-insurance***	***Co-payment/Co-insurance***
preventive care	$0	$0	$0	$0
primary care office visit	$25	$25	deductible, then 20% co-insurance	deductible, then 20% co-insurance
mental health/substance abuse office visit	$25	$25	deductible, then 20% co-insurance	deductible, then 20% co-insurance
specialist office visit	$35	$35	deductible, then 20% co-insurance	deductible, then 20% co-insurance
urgent care	$75	deductible, then 20% co-insurance	deductible, then 20% co-insurance	deductible, then 20% co-insurance
emergency room	$250	deductible, then 20% co-insurance	deductible, then 20% co-insurance	deductible, then 20% co-insurance
ambulance	deductible, then 20% co-insurance	deductible, then 20% co-insurance	deductible, then 20% co-insurance	deductible, then 20% co-insurance
durable medical equipment	deductible, then 20% co-insurance	deductible, then 20% co-insurance	deductible, then 20% co-insurance	deductible, then 20% co-insurance
radiology (MRI, CT, PET)	deductible, then 20% co-insurance	deductible, then 20% co-insurance	deductible, then 20% co-insurance	deductible, then 20% co-insurance
outpatient	deductible, then 20% co-insurance	deductible, then 20% co-insurance	deductible, then 20% co-insurance	deductible, then 20% co-insurance
inpatient	deductible, then 20% co-insurance	deductible, then 20% co-insurance	deductible, then 20% co-insurance	deductible, then 20% co-insurance
vision exam	$20	$20	$20	$20
Service Categories	***Co-payment/Co-insurance***	***Co-payment/Co-insurance***	***Co-insurance***	***Co-insurance***
wellness drugs #	n/a	n/a	0%	0%
generic tier 1	$4	$4	deductible, then 20% co-insurance	deductible, then 20% co-insurance
generic tier 2	$10	$10	deductible, then 20% co-insurance	deductible, then 20% co-insurance
preferred brand	$20	$20	deductible, then 20% co-insurance	deductible, then 20% co-insurance
non-preferred brand	50%	50%	deductible, then 20% co-insurance	deductible, then 20% co-insurance
compatible with: Health Reimbursement Arrangement (HRA) Health Savings Account (HSA)	HRA	HRA	HRA, HSA	HRA, HSA

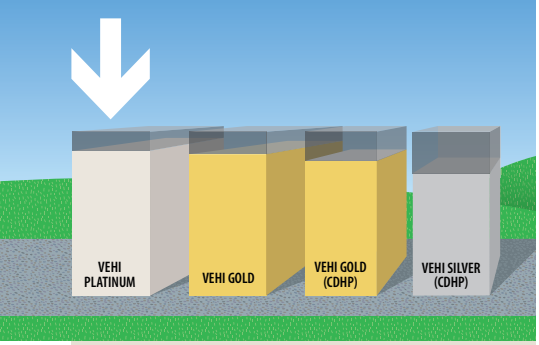


* CDHP–Consumer Directed Health Plan

^ stacked–See definition at left.

** aggregate–See definition at left.

\# wellness drugs–**www.bcbsvt.com/wellnessrx**



VEHI Platinum information

Compatible with an HRA

General cost-sharing (applies to some services before your plan provides benefits)

Medical deductible (stacked)

- $500 if you have an individual plan
- $1,000 if you have a two-person, parent and child or family plan
- Your deductible applies to covered medical services and supplies

Prescription drug out-of-pocket limit (stacked)

- $1,300 if you have an individual plan
- $2,600 if you have a two-person, parent and child or family plan

Medical out-of-pocket limit (stacked)

- $1,500 if you have an individual plan
- $3,000 if you have a two-person, parent and child or family plan

Total out-of-pocket exposure (stacked)

- $2,800 if you have an individual plan
- $5,600 if you have a two-person, parent and child or family plan

Understanding your medical deductible

This plan has a stacked medical deductible.

For individuals, you must meet the $500 deductible before VEHI begins paying for applicable medical services.

If you're on a two-person, parent and child or family plan, a covered family member may meet the individual deductible of $500 and begin receiving post-deductible benefits for their care. When your family members' covered expenses reach the family deductible of $1,000, all family members receive post-deductible benefits.

Covered medical services and supplies accumulate towards this amount throughout your calendar year.

Understanding your medical out-of-pocket limit

This plan has a stacked medical out-of-pocket limit.

For individuals, you must meet the $1,500 medical out-of-pocket limit before VEHI pays 100 percent of the allowed amount for all covered medical expenses for the rest of the year.

If you're on a two-person, parent and child or family plan, a covered family member may meet the individual medical out-of-pocket limit of $1,500 and VEHI will begin to pay 100 percent of the allowed amount for eligible medical services for that individual.

Additionally, any combination of covered family members may meet the family medical out-of-pocket limit of $3,000 and VEHI will begin to pay 100 percent, of the allowed amount, for all covered family members for the rest of the calendar year.

Your plan has a separate, stacked out-of-pocket limit for prescription drugs.

Understanding your prescription drug out-of-pocket limit

This plan has a stacked prescription drug out-of-pocket limit.

For individuals, you must meet the $1,300 prescription drug out-of-pocket limit before VEHI pays 100 percent of the allowed amount for prescription drugs.

If you're on a two-person, parent and child or family plan, a covered family member may meet the individual out-of-pocket limit of $1,300 and VEHI will begin to pay 100 percent of the allowed amount for eligible services for that individual.

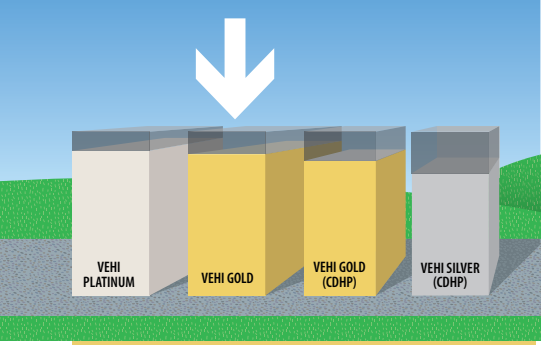
Additionally, any combination of covered family members may meet the family prescription drug out-of-pocket limit of $2,600 and VEHI will begin to pay 100 percent, of the allowed amount,for all family members for the rest of the calendar year.

Remember, prescription drugs have a separate out-of-pocket limit from your medical out-of-pocket limit. This means you may meet your out-of-pocket limit for prescription drugs, but still be responsible for paying for medical costs until you reach your plan's medical out-of-pocket limit.

Watch for VEHI's online videos for a more detailed understanding of the VEHI Platinum and Gold plans.

VEHI Platinum cost-sharing

(NETWORK PROVIDERS ONLY)	YOU PAY	VEHI PAYS
OUTPATIENT CARE		
preventive care (see page 10) Includes well baby, adult preventive, gynecological preventive office visits; includes preventive services such as laboratory, screening mammograms, Pap tests and colonoscopies. Excludes diagnostic services.	No member cost	100% of the allowed amount
primary care provider office visits	$25 co-payment	All but your co-payment
mental health and substance abuse office visits	$25 co-payment	All but your co-payment
specialist office visits may require prior approval	$35 co-payment	All but your co-payment
maternity office visits	One $25 co-payment for all prenatal and post-partum care from one provider	All but your co-payment
chiropractic care prior approval required after 12 visits per year	$35 co-payment	All but your co-payment
diagnostic services includes labs, X-ray, etc.; may require prior approval	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100%.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
outpatient surgery prior approval may be required		
outpatient physical, occupational and speech therapy up to 30 visits combined per calendar year		
urgent care at an urgent care facility	$75 co-payment	All but your co-payment
emergency care	$250 co-payment (waived if admitted)	All but your co-payment
INPATIENT CARE		
inpatient care, general hospital Includes maternity, newborn care, mental health and substance abuse.	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
HOME CARE AND REHABILITATION SERVICES		
inpatient skilled nursing or rehabilitation prior approval required for rehabilitation	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
home health and hospice care services prior approval required		
private duty nursing up to 14 hours per member per calendar year		
OTHER SERVICES		
ambulance prior approval required for non-emergency transport	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
medical equipment and supplies prior approval may be required		
vision exam one exam per year	$20 per exam	All but your co-payment
PRESCRIPTION DRUGS		
prescription drugs (including home delivery) prior approval may be required	Your cost-sharing: ▪ $4 co-payment for generics on Tier 1 (lower-cost generics) ▪ $10 co-payment for generics on Tier 2 (higher-cost generics) ▪ $20 co-payment for preferred brand-name drugs ▪ 50% co-insurance for non-preferred brand-name drugs. For individuals, your prescription costs are limited to $1,300 each year, or $2,600 each year if you have a family plan.	All but your co-insurance and co-payments at left. VEHI pays 100% of the allowed amount if you meet your prescription drug out-of-pocket limit of $1,300 for a single plan or $2,600 for a two-person, parent/child or family plan. This is a stacked out-of-pocket limit.



VEHI Gold information

Compatible with an HRA

General cost-sharing (applies to some services before your plan provides benefits)

Medical deductible (stacked)

- $1,200 if you have an individual plan
- $2,400 if you have a two-person, parent and child or family plan
- Your deductible applies to covered medical services and supplies

Prescription drug out-of-pocket limit (stacked)

- $1,300 if you have an individual plan
- $2,600 if you have a two-person, parent and child or family plan

Medical out-of-pocket limit (stacked)

- $1,800 if you have an individual plan
- $3,600 if you have a two-person, parent and child or family plan

Total out-of-pocket exposure (stacked)

- $3,100 if you have an individual plan
- $6,200 if you have a two-person, parent and child or family plan

Understanding your medical deductible

This plan has a stacked medical deductible.

For individuals, you must meet the $1,200 deductible before VEHI begins paying benefits for applicable services.

If you're on a two-person, parent and child or family plan, a covered family member may meet the individual medical deductible of $1,200 and begin receiving post-deductible benefits for their care. When your family members' covered expenses reach the family medical deductible of $2,400 all family members receive post-deductible benefits.

Covered medical services and supplies accumulate towards this amount throughout your calendar year.

Understanding your medical out-of-pocket limit

This plan has a stacked medical out-of-pocket limit.

For individuals, you must meet the $1,800 medical out-of-pocket limit before VEHI pays 100 percent of the allowed amount for all covered expenses for the rest of the year.

If you're on a two-person, parent and child or family plan, a covered family member may meet the individual medical out-of-pocket limit of $1,800 and VEHI will begin to pay 100 percent of the allowed amount for eligible medical services for that individual.

Additionally, any combination of covered family members may meet the family medical out-of-pocket limit of $3,600 and VEHI will begin to pay 100 percent, of the allowed amount, for all covered family members for the rest of the calendar year.

Your plan has a separate, stacked out-of-pocket limit for prescription drugs.

Understanding your prescription drug out-of-pocket limit

This plan has a stacked prescription drug out-of-pocket limit.

For individuals, you must meet the $1,300 prescription drug out-of-pocket limit before VEHI pays 100 percent of the allowed amount for prescription drugs.

If you're on a two-person, parent and child or family plan, a covered family member may meet the individual out-of-pocket limit of $1,300 and VEHI will begin to pay 100 percent of the allowed amount for eligible services for that individual.

Additionally, any combination of covered family members may meet the family prescription drug out-of-pocket limit of $2,600 and VEHI will begin to pay 100 percent, of the allowed amount,for all family members for the rest of the calendar year.

Remember, prescription drugs have a separate out-of-pocket limit from your medical out-of-pocket limit. This means you may meet your out-of-pocket limit for prescription drugs, but still be responsible for paying for medical costs until you reach the medical out-of-pocket limit.

Watch for VEHI's online videos for a more detailed understanding of the VEHI Platinum and Gold plans.

VEHI Gold cost-sharing

(NETWORK PROVIDERS ONLY)	YOU PAY	VEHI PAYS
OUTPATIENT CARE		
preventive care (see page 10) Includes well baby, adult preventive, gynecological preventive office visits; includes preventive services such as laboratory, screening mammograms, Pap tests and colonoscopies. Excludes diagnostic services.	No member cost	100% of the allowed amount
primary care provider office visits	$25 co-payment	All but your co-payment
mental health and substance abuse office visits	$25 co-payment	All but your co-payment
specialist office visits may require prior approval	$35 co-payment	All but your co-payment
maternity office visits	One $25 co-payment for all prenatal and post-partum care from one provider	All but your co-payment
chiropractic care prior approval required after 12 visits per year	$35 co-payment	All but your co-payment
diagnostic services includes labs, X-ray, etc.; may require prior approval	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
outpatient surgery prior approval may be required		
outpatient physical, occupational and speech therapy up to 30 visits combined per calendar year		
urgent care		
emergency care		
INPATIENT CARE		
inpatient care, general hospital Includes maternity, newborn care, mental health and substance abuse.	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
HOME CARE AND REHABILITATION SERVICES		
inpatient skilled nursing or rehabilitation prior approval required for rehabilitation	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
home health and hospice care services prior approval required		
private duty nursing up to 14 hours per member per calendar year		
OTHER SERVICES		
ambulance prior approval required for non-emergency transport	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
medical equipment and supplies prior approval may be required		
vision exam one exam per year	$20 per exam	All but your co-payment
PRESCRIPTION DRUGS		
prescription drugs (including home delivery) prior approval may be required	Your cost-sharing: ▪ $4 co-payment for generics on Tier 1 (lower-cost generics) ▪ $10 co-payment for generics on Tier 2 (higher-cost generics) ▪ $20 co-payment for preferred brand-name drugs ▪ 50% co-insurance for non-preferred brand-name drugs. For individuals, your prescription costs are limited to $1,300 each year, or $2,600 each year if you have a family plan.	All but your co-insurance and co-payments at left. VEHI pays 100% of the allowed amount if you meet your prescription drug out-of-pocket limit of $1,300 for a single plan or $2,600 for a two-person or family plan. This is a stacked out-of-pocket limit.

CDHPs (compatible with HSAs or HRAs)

VEHI's health plans can be integrated with tax-advantaged spending accounts to cover the costs of qualified medical expenses. This section provides introductory explanations of:

- **Consumer-Directed Health Plans (see page 31 amd page 33 for VEHI's CDHP offerings)**
- **Qualified health care expenses**
- **Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs).**

You can find more detailed information on the VEHI website, **vehi.org**.

What is a CDHP?

A CDHP is a consumer-directed health plan (sometimes referred to as a consumer-driven health plan). VEHI uses the term CDHP for its health plans that can be paired with Health Savings Accounts (HSAs).

VEHI's CDHP plans also pair with Health Reimbursement Arrangements (as do all health plans); however, VEHI's non-CDHP plans may not, under federal law, be paired with HSAs.

In order to be paired with an HSA, in conformance with tax law, a plan must meet IRS cost-sharing requirements. Two of VEHI's plans—Gold CDHP and Silver CDHP—meet this criteria.

What are Health Reimbursement Arrangements (HRAs)?

HRAs are tax-favored accounts from which employees may draw employer-sponsored funds to cover qualified medical expenses. An HRA is set up and funded only by an employer with support, generally, from a Third Party Administrator such as HealthEquity or Future Planning. Employers that offer HRAs must develop plan documents stating for which "qualified medical expenses" (see sidebar on the next page) their employees may use HRA funds.

Employers and local unions can decide which qualified services HRA funds can cover. A plan document may be structured to permit the use of HRA funds to cover all or some portion of deductibles, co-payments and/or co-insurance expenses. If an employer's plan document allows it, employees may also use HRA funds to pay for costs considered qualified medical expenses by the IRS, but not covered by a health plan. When employees use HRA funds for these expenses, they must complete paper claim forms to get reimbursement from the HRA administrator, as these claims are not integrated through the BCBSVT claims feed.

Funds not used by employees in a calendar year generally remain with the employer. Employers may opt to allow funds to carry over from year to year. When an employee leaves employment, HRA funds stay with the employer. Note, however, that employees can retain access to their HRAs if they elect coverage under federal COBRA continuation of coverage requirements. Employers must then continue to make contributions equal to those they make for similarly situated active employees.

All four VEHI plans may be paired with HRAs. Contact your group benefits manager at the time of enrollment to see if an HRA is available.

What are Health Savings Accounts (HSAs)?

An HSA is also a tax-favored health care spending account. An HSA account may be available to school employees who are enrolled in the VEHI Gold CDHP or the VEHI Silver CDHP.

Employees may draw funds from their HSAs to cover costs of qualified services, including deductibles, co-insurance and other costs considered "qualified medical expenses" by the IRS, but not covered by a health plan.

Federal tax laws determine the criteria for which health plans can be paired with HSAs. To understand these limits, as regulated by the IRS, please see **IRS.gov/pub969**.

HSAs are set up by employees and can be funded by the employee or by both employees and employers. The IRS limits the amount that may be contributed to an HSA each year, and that amount may be increased periodically by the federal government.

If an employer contributes on behalf of an employee, the amount the employee may contribute is reduced by the amount the employer puts in the account. Employer contributions are considered as employer-provided coverage and the employer may exclude them from the employee's gross income. Employers and their employees may make contributions in one or more payments.

The funds in an HSA, even those contributed by an employer, belong to an employee, even if the employee doesn't use them in the current calendar year, or if the employee leaves employment.

Employees can save money tax-free for health care costs, and roll those unused funds over year after year. Financial gains come from coupling tax-free earnings with smart purchasing decisions, like using lower-cost generic drugs. The HSA acts like a 401(k) for health care. You can save for medical expenses throughout your life. You can even use HSA funds to pay for Medicare premiums, as well as qualified medical expenses, after you turn 65.

Employees may select any financial institution that offers the service to set up and manage an HSA.

It is important to know the expenses for which you may use your tax-favored HSA. (See "What are 'qualified medical expenses'?" at the right.) The IRS imposes penalties for using HSA funds for non-qualified expenses. This penalty may include a percentage of the cost of the service, plus the loss of tax-free treatment for the distribution if you are under age 65. Keep all itemized receipts and copies of prescriptions for over-the-counter medications in case of an IRS audit.

HSA Considerations

Current Federal law determines eligibility to make or receive contributions to an HSA in a given calendar year. The following employees at present are not eligible to make or receive contributions to an HSA:

- Those who have applied for or enrolled in Medicare or Social Security;
- Those in TRICARE, a health benefits program for veterans;
- Those who have primary or secondary coverage on a spouse's health plan.
- Those who have a medical FSA.

Keep in mind that individuals can continue to use any funds already in their HSA to pay for qualified medical expenses for themselves and their tax dependents as listed in IRS publication 502.

Also, parents can use money from their HSA to cover IRS-approved, out-of-pocket costs for an adult child on their health plan only if the child is a tax dependent or, in the case of a child aged 24-26, only if the child is totally and permanently disabled. Non-dependent adult children can set up and contribute to their own HSAs.

For more information, please visit **VEHI.org** or **IRS.gov/pub969**.

What are "qualified medical expenses"?

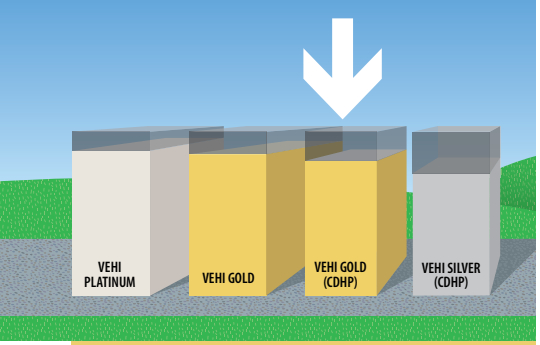
The IRS determines expenses for which you may use tax-favored accounts. They are called "qualified medical expenses." They include medical, dental, vision and prescription expenses. IRS publication 502 (**www.irs.gov/publications/p502/**) provides an exhaustive list. Here are examples:

- Cost-sharing you must pay when your health plan provides benefits, such as:
  - Deductibles
  - Co-insurance
  - Co-payments
- Expenses for services that may not be covered by your health plan, such as:
  - Acupuncture
  - Contact lenses
  - Dental treatments
  - Hearing aids
  - Over-the-counter medicines (only with a prescription)
  - Orthodontia
  - Tobacco cessation therapy
  - Telephone equipment for the hearing-impaired
  - Weight-loss program (as prescribed)
  - Wigs (as prescribed)

Examples of services that are <u>not</u> qualified medical expenses include:

- Concierge services
- Dancing lessons
- Diaper service
- Elective cosmetic surgery
- Electrolysis or hair removal
- Funeral expenses
- Hair transplants
- Health club dues
- Insurance premiums (except long-term care premiums or Medicare Part A, B or D premiums paid by individuals over age 65)

The IRS does not allow HSA funds to be used for over-the-counter (OTC) medicines without a prescription. You may want to ask your doctor if he or she can write a prescription for OTC medicines or supplies that you use frequently. Then you can use your HSA to pay for these items.



VEHI Gold Consumer-Directed Health Plan (CDHP) information

Compatible with HRAs and HSAs

General cost-sharing (applies to most services before your plan provides benefits)

Deductible (aggregate)

- 1,800 if you have an individual plan
- $3,600 if you have a two-person, parent and child or family plan
- Your deductible applies to covered medical services and supplies and prescription drug services and supplies

Prescription drug out-of-pocket limit (aggregate)

- $1,350 if you have an individual plan
- 2,700 if you have a two-person, parent and child or family plan
- Your prescription drug out-of-pocket limit accrues towards your total out-of-pocket limit

Total out-of-pocket limit (aggregate)

- $2,500 if you have an individual plan
- $5,000 if you have a two-person, parent and child or family plan

Understanding your deductible

This plan has an aggregate deductible.

For an individual plan, you must meet the $1,800 deductible before VEHI begins paying benefits for applicable services.

If you're on a two-person, parent and child or family plan, your family's combined covered expenses must meet the entire $3,600 deductible each year before VEHI begins paying benefits for most services.

Covered medical services and supplies and prescription drug services and supplies accumulate towards this amount throughout your calendar year.

Understanding your total out-of-pocket limit

This plan has an aggregate out-of-pocket limit.

For an individual plan, you must meet the $2,500 overall out-of-pocket limit before VEHI pays 100 percent of the allowed amount for all covered expenses for the rest of the year.

If you're on a two-person, parent and child or family plan, your family's combined expenses must meet the entire $5,000 total out-of-pocket limit, before VEHI pays 100 percent, of the allowed amount, for all eligible services for the rest of the calendar year.

This prescription drug out-of-pocket limit counts towards your total out-of-pocket limit.

Understanding your prescription drug out-of-pocket limit

This plan has an aggregate prescription drug out-of-pocket limit.

For an individual plan, you must meet the $1,350 prescription drug out-of-pocket limit before VEHI pays 100 percent of the allowed amount for prescription drugs.

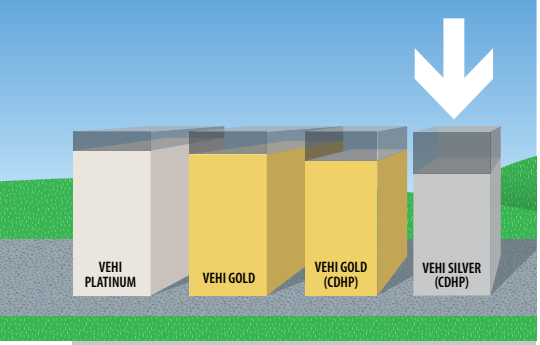
If you're on a two-person, parent and child or family plan, your entire family's combined expenses must meet the $2,700 prescription drug out-of-pocket limit before VEHI pays 100% of the allowed amount for covered prescription drug expenses for the rest of the calendar year.

Remember, prescription drugs have a lower out-of-pocket limit from your total out-of-pocket limit. This means you may meet your out-of-pocket limit for prescription drugs, but still be responsible for paying for medical costs until you reach your plan's total out-of-pocket limit.

Watch for VEHI's online videos for a more detailed understanding of the VEHI Gold CDHP and Silver CDHP plans.

VEHI Gold Consumer-Directed Health Plan (CDHP) cost-sharing

(NETWORK PROVIDERS ONLY)	YOU PAY	VEHI PAYS
OUTPATIENT CARE		
preventive care (see page 10) Includes well baby, adult preventive, gynecological preventive office visits; includes preventive services such as laboratory, screening mammograms, Pap tests and colonoscopies. Excludes diagnostic services.	No member cost	100% of the allowed amount
primary care provider office visits	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
mental health and substance abuse office visits		
specialist office visits may require prior approval		
maternity office visits		
chiropractic care prior approval required after 12 visits per year		
diagnostic services includes labs, X-ray, etc.; may require prior approval		
outpatient surgery prior approval may be required		
outpatient physical, occupational and speech therapy up to 30 visits combined per calendar year		
emergency and urgent care		
INPATIENT CARE		
inpatient care, general hospital Includes maternity, newborn care, mental health and substance abuse.	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
HOME CARE AND REHABILITATION SERVICES		
inpatient skilled nursing or rehabilitation prior approval required for rehabilitation	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
home health and hospice care services prior approval required		
private duty nursing up to 14 hours per member per calendar year		
OTHER SERVICES		
ambulance prior approval required for non-emergency transport	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
medical equipment and supplies prior approval may be required		
vision exam one exam per year	$20 per exam	All but your co-payment
PRESCRIPTION DRUGS		
prescription drugs (including home delivery) prior approval may be required	Deductible, then 20% co-insurance until you meet your prescription drug out-of-pocket limit of $1,350 for a single plan or $2,700 for other coverage. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit of $1,350 for a single plan or $2,700 for other coverage. After that, VEHI pays 100% of the allowed amount for the rest of the year. This is an aggregate out-of-pocket limit.
wellness drugs Visit **www.bcbsvt.com/wellnessrx** to find a list.	For certain drugs that prevent or treat a chronic illness, you do not have to pay your deductible or co-insurance. VEHI covers those drugs at 100% of the allowed amount.	100% of the allowed amount.



VEHI Silver Consumer-Directed Health Plan (CDHP) information

Compatible with HRAs and HSAs

General cost-sharing (applies to most services before your plan provides benefits)

Deductible (stacked)

- 3,000 if you have an individual plan
- $6,000 if you have a two-person, parent and child or family plan
- Your deductible applies to covered medical services and supplies and prescription drug services and supplies

Prescription drug out-of-pocket limit (aggregate)

- $1,350 if you have an individual plan
- 2,700 if you have a two-person, parent and child or family plan
- Your prescription drug out-of-pocket limit accrues towards your total out-of-pocket limit

Total out-of-pocket limit (stacked)

- $4,000 if you have an individual plan
- $8,000 if you have a two-person, parent and child or family plan

Understanding your deductible

This plan has a stacked deductible .

For individuals, you must meet the $3,000 deductible before VEHI begins paying benefits for applicable services.

If you're on a two-person, parent and child or family plan, a covered family member may meet the individual deductible of $3,000 and begin receiving post-deductible benefits for their care. When your family's covered expenses reach the family deductible of $6,000, all family members receive post-deductible benefits.

Covered medical services and supplies and prescription drug services and supplies accumulate towards this amount throughout your calendar year.

Understanding your total out-of-pocket limit

This plan has a stacked total out-of-pocket limit.

For individuals, you must meet the $4,000 out-of-pocket limit before VEHI pays 100 percent of the allowed amount for all covered expenses for the rest of the year.

If you're on a two-person, parent and child or family plan, a covered family member may meet the individual out-of-pocket limit of $4,000 and VEHI will begin to pay 100 percent of the allowed amount for eligible services for that individual.

Additionally, any combination of covered family members may meet the two-person, parent and child or family total out-of-pocket limit of $8,000 and VEHI will begin to pay 100 percent of the allowed amount for eligible services, for the rest of the calendar year.

Your plan has a lower out-of-pocket limit for prescription drugs. This prescription drug out-of-pocket limit accrues towards your total out-of-pocket limit.

Understanding your prescription drug out-of-pocket limit

This plan has an aggregate prescription drug out-of-pocket limit.

For individuals, you must meet the $1,350 prescription drug out-of-pocket limit before VEHI pays 100 percent of the allowed amount for prescription drugs.

If you're on a two-person, parent and child or family plan, your entire family's expenses combined must meet the $2,700 out-of-pocket limit, before VEHI pays 100% of the allowed amount for covered prescription drug expenses for the rest of the year.

Remember, prescription drugs have a lower out-of-pocket limit from your overall out-of-pocket limit. This means you may meet your out-of-pocket limit for prescription drugs, but still be responsible for paying for medical costs until you reach your plan's overall out-of-pocket limit.

Watch for VEHI's online videos for a more detailed understanding of the VEHI Gold CDHP and Silver CDHP plans.

VEHI Silver Consumer-Directed Health Plan (CDHP) cost-sharing

(NETWORK PROVIDERS ONLY)	YOU PAY	VEHI PAYS
OUTPATIENT CARE		
preventive care (see page 10) Includes well baby, adult preventive, gynecological preventive office visits; includes preventive services such as laboratory, screening mammograms, Pap tests and colonoscopies. Excludes diagnostic services.	No member cost	100% of the allowed amount
primary care provider office visits	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
mental health and substance abuse office visits		
specialist office visits may require prior approval		
maternity office visits		
chiropractic care prior approval required after 12 visits per year		
diagnostic services includes labs, X-ray, etc.; may require prior approval		
outpatient surgery prior approval may be required		
outpatient physical, occupational and speech therapy up to 30 visits combined per calendar year		
emergency and urgent care		
INPATIENT CARE		
inpatient care, general hospital Includes maternity, newborn care, mental health and substance abuse.	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
HOME CARE AND REHABILITATION SERVICES		
inpatient skilled nursing or rehabilitation prior approval required for rehabilitation	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
home health and hospice care services prior approval required		
private duty nursing up to 14 hours per member per calendar year		
OTHER SERVICES		
ambulance prior approval required for non-emergency transport	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
medical equipment and supplies prior approval may be required		
vision exam one exam per year	$20 per exam	All but your co-payment
PRESCRIPTION DRUGS		
prescription drugs (including home delivery) prior approval may be required	Deductible, then 20% co-insurance until you meet your prescription drug out-of-pocket limit of $1,350 for a single plan or $2,700 for family coverage. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit of $1,350 for a single plan or $2,700 for family coverage. After that, VEHI pays 100% of the allowed amount for the rest of the year. This is an aggregate out-of-pocket limit.
wellness drugs Visit **www.bcbsvt.com/wellnessrx** to find a list.	For certain drugs that prevent or treat a chronic illness, you do not have to pay your deductible or co-insurance. VEHI covers those drugs at 100% of the allowed amount.	100% of the allowed amount.

Better care through Blue Health Solutions℠

Blue Health Solutions is BCBSVT's suite of customized health and wellness programs and solutions designed to help employees achieve and maintain optimal health at every stage of life. This program supports members in getting the right care and screenings and helps them be successful with their providers' treatment plans. We also provide a local touch when it comes to providing case management and health support for chronic and rare conditions.

Staying healthy

Above all else, we want you to stay healthy. That's why we offer many different ways to engage you in maintaining a healthy lifestyle.

Fitness and health events

Blue Cross and Blue Shield of Vermont holds many signature events each year that help Vermonters get out and get active. They range from walking challenges at Vermont worksites to "Hike, Bike & Paddle" events at Vermont lakes and ponds to "Apple Days" and "Snow Days" at some of BCBSVT's state's most beautiful venues. See the updated calendar at **www.bcbsvt.com/calendar**.

Blue Extras Health and Wellness Program℠

BCBSVT's Blue Extras Health and Wellness Program gives you discounts on area health, fitness, nutrition and wellness resources—even recreational activities in your communities. To check out the growing list of discounted services and other items, visit **www.bcbsvt.com/blueextras**.

My Blue Health and Wellness Center℠

By using the tools on the My Blue Health and Wellness Center (**mybluehealth.bcbsvt.com**), you can create and manage health improvement programs designed especially for your specific needs— track your diet, exercise and overall health. My Blue Health and Wellness Center features a number of exercise tools that allow you to track your physical activity, as well as gain access to fitness plans and exercise demos. You can use My Blue Health on your mobile devices, making it easy to track while you're on the go. Please see page 36 to learn more about VEHI's PATH program.

Consumer support tools

Access thousands of evidence-based, easy-to-understand explanations and tools on medical conditions, symptoms, tests and treatments through Healthwise® Knowledgebase. Some common topics include:

- Head injury
  - Concussion
  - Traumatic brain injury (TBI)
- Pregnancy and childbirth Infections
  - Avoiding infections while in the hospital
  - Preventing infection
- Surgical safety:
  - Preparing for surgery
  - Postoperative problems
- Safety:
  - Home safety
  - Personal safety

Better Beginnings®

BCBSVT's popular Better Beginnings program helps moms-to-be create the healthiest, happiest start for their baby. Better Beginnings offers pregnancy and postpartum support.

When a mom-to-be enrolls in the program, one of BCBSVT's Better Beginnings nurses will work with her chosen health care provider to promote healthy outcomes. The Better Beginnings program has played an important role in lowering BCBSVT's state's premature birth rate. A premature birth is not only dangerous for a baby, but also for a mother. BCBSVT's Better Beginnings nurse will work directly with a mom-to-be to identify any risks that could lead to complications with her pregnancy and help to reduce those risks. The program offers a choice of several different benefit options. If you sign up before your 34th week of pregnancy, you are eligible for an enhanced benefit.

A sample of benefits includes:

- Homemaker services for house cleaning
- Reimbursements toward a car seat
- Reimbursements toward birthing or fitness classes
- The choice of a book from BCBSVT's specially selected Better Beginnings book list

BCBSVT's Better Beginnings nurse will review the program benefits with each participant. Because every pregnancy is different, we tailor the program to meet individual needs. To learn more about Better Beginnings, visit **www.bcbsvt.com/betterbeginnings**.

path
PLANNED ACTION TOWARD HEALTH

For more information about VEHI's PATH program, please see page 36 . You may also earn PATH points for engaging in one of the Blue Health Solutions programs!

Getting better

Case management

If you suffer a catastrophic health event or have a complex condition, BCBSVT has a case management program to help. While your primary care provider is the best resource for your medical questions and concerns, a case manager serves as your dedicated advocate at BCBSVT. Your case manager will coordinate benefits and find programs, services and support systems that can help support you and your family.

BCBSVT has a staff of licensed professional nurses and social workers on hand to help you. In addition to assessing your health status and current needs, BCBSVT's case managers are interested in getting to know you on a personal level in order to support you better. Case managers will help you decide your personal health goals, take action on those goals and coordinate with your health care providers to help you reach your goals.

BCBSVT's case managers may:

- provide educational materials about your conditions
- create treatment plans
- coordinate resources so that you get timely and affordable care and use your benefits in the best way
- assist in helping you to find alternative funding, if necessary; and
- help you find transportation if necessary and available

If you have any questions concerning case management, or are interested in learning more about BCBSVT's case management program, please call (800) 922-8778 and choose option 1.

Living with illness

Chronic condition management

As a BCBSVT member, you are not alone if you're suffering from a chronic condition. BCBSVT's nurses are standing by to assist you in achieving and maintaining your health through a variety of means. Through BCBSVT's chronic condition program, BCBSVT may send you helpful information about your conditions and give you access to BCBSVT's nursing staff and other resources to help you make lifestyle changes that are critical for your overall health improvement.

We offer help for a variety of chronic conditions including:

- Asthma
- COPD
- Diabetes
- Heart disease, or coronary disease
- Heart failure

A nurse may reach out to you about your condition to be sure that you are getting the best care and screening available and help you stay on track with your treatment plan. Any conversations are strictly confidential and participation in the program is always voluntary.

Rare condition management

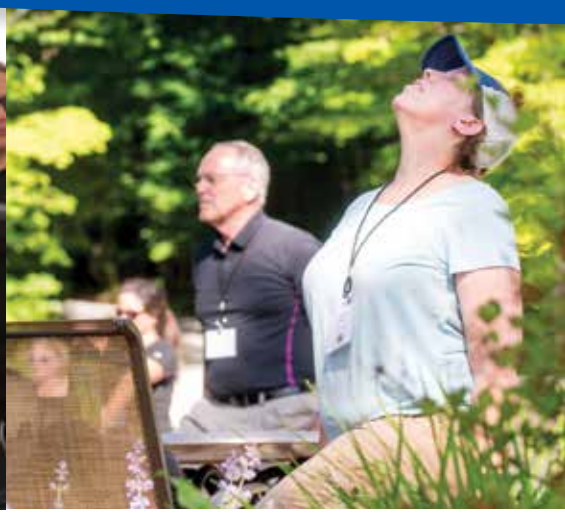
Some conditions are less prevalent, making them potentially hard to manage, but BCBSVT can offer specialized help when local support may be hard to find. We can connect you to nurses who have expert knowledge of rare conditions. This one-on-one help is designed to improve your total health and help you manage your complex conditions. Support could include symptom management, self-care support, medication optimization and care optimization.

Rare conditions addressed through BCBSVT's program include

- ALS
- CIDP
- Crohn's Disease
- Cystic Fibrosis
- Dermatomyositis
- Gaucher Disease
- Hemophilia
- Lupus
- Multiple Sclerosis (MS)
- Myasthenia Gravis
- Parkinson's Disease
- Polymyositis
- Rheumatoid Arthritis
- Scleroderma
- Seizure Disorders
- Sickle Cell Disease
- Ulcerative Colitis

For more information on one of BCBSVT's management programs, please call BCBSVT's integrated health team at (800) 922-8778.

Employee wellness program



VEHI's employee wellness program, PATH (since 1991), offers members state of the art services to build and maintain healthy behaviors at work, at home and in the community. We want to help you live your best life in a safe and healthy environment. To do so, we provide you with a smattering of ways to gain skills, knowledge and strategies about physical, emotional, social and spiritual health.

- ✓Create a VEHI PATH account or access the one you've already set up (**www.tomyPATH.com**)
- ✓Take advantage of our many services and activities
- ✓Earn PATHpoints and incentive rewards
- ✓Share newfound skills and information with your household members
- ✓Invest in making your workplace safer and healthier with the help of your colleagues
- ✓Access Blue Health Solutions including Better Beginnings and case management programs
- ✓Participate in BCBSVT winter and summer outdoor events

PATH Adventures—These themed annual 10-week virtual wellness challenges focus on fitness, healthy eating and stress management. Championed by coordinators in schools across Vermont, participants report the following:

- 93% report a significant increase in staff morale during the Adventure
- 85% report at least one employee who's made a life-saving lifestyle change
- 65% report increasing their physical activity, 59% report feeling healthier all around and 30% report losing weight

Healthy Life Survey—This assessment tool is designed to take a snapshot of your health, spotting potential risks while highlighting the positive. Take this survey annually to compare your results and see how your health is improving.

PATH Community and Keeping Fit—This online tracking tool allows you to record your workouts, sleep, flexibility and character all year. Join a team for added support or a bit of competition, or activate a cycle to earn PATHpoints in Keeping Fit.

Progress Health Coaching—This telephonic coaching service is staffed by certified professionals and is designed to help you find your best thinking around your lifestyle goals. Coaches work with you via phone appointments, conveniently scheduled to fit into your day.

Peer Coaching Course—This online course provides you and your peer with the skills necessary to give and receive quality support for reaching a health-related goal.

EAP COUNSELOR
Employee assistance program for life's major stressors.
50 points

PEER COACHING
Structured mutual support for health goals.
50 points

KNOW YOUR NUMBERS
Have your annual wellness visit.
25 points

PATH PUZZLERS
Safety and first aid tips made fun.
60 points

COMMUNITY AND KEEPING FIT
Online goal tracking.
120 points possible

WELLNESS LEADER EVENTS
Wellness events organized by your building leader.
40 points possible

SIZZLIN' SUMMER CHALLENGE
Friends and family fun.
25 points

Invest EAP —The employee assistance program is here to help you and members of your household cope with stress, loss and major life changes. Meet face to face with a mental health clinician, talk with an attorney or financial counselor or access valuable resources, such as child and elder care services, by visiting their website.

Safety Puzzlers—These monthly crossword puzzles and safety information provide you the opportunity to brush up on your skills and knowledge for avoiding injury. Read the information and try your hand at solving each puzzle.

Sizzlin' Summer Challenge —This weekly summer challenge is all about taking photos of some light hearted family health goals, sharing them on our Facebook page and qualifying for the grand prize. It's stress free and fun for all members of your household.

Thriving in the Workplace—VEHI PATH supports wellness leaders in your workplace to help you access each of the PATH program elements. They work hard to bring employee wellness and all aspects of a healthy culture to you, including offering tailored events to boost your total well-being and social support. Connect with your building leader for more information and support.

Intensive Wellness Institutes—PATH offers one intensive wellness institute to district and supervisory union teams each summer. Talk with your building leader about possible participation.

VEHI PATH is here for you. Access your account today and start living your best life.

PATH ADVENTURES
10-week challenge.
50 points possible

PROGRESS COACHING
Professional coaching for lasting change.
50 points possible

SHOW YOUR SMILE
Have your annual dental check up.
25 points possible

Frequently asked questions

1. How do the covered medical services differ in the health plans offered?

All plans cover all of the same services, including a vision exam for all covered members. They may have different cost-sharing depending on the plan selection.

2. What are the key differences between the co-payment plans and consumer-directed health plans?

The co-payment style plans (VEHI Platinum and VEHI Gold) have co-payments for certain benefits and deductible and co-insurance for others.

The Gold and Silver CDHPs have no co-payments (except for vision exams) and all services are subject to deductible and co-insurance with the exception of wellness prescriptions, preventive care services and vision exams. Preventive care services are covered at no cost to you on all plans.

All four plans are Health Reimbursement Arrangement compatible. Only the CDHPs are Health Savings Account compatible.

3. Can family members select different coverages?

No. All family members must be on the same plan.

4. If I choose a plan, can I later change my mind and choose a different plan?

Yes. Regardless of which plan you initially select, you may change plans during your employer's open enrollment period (see "Membership information" on page 6).

Please see your group's benefit manager for details.

5. Can I use the same medical providers?

Yes, in most instances. VEHI and BCBSVT reviewed the list of medical providers used by VEHI members and found that 96% of those providers are in BCBSVT's network.

Everyone in VEHI will use the same network and everyone will need to identify a primary care provider. You can use the BCBSVT Network for care in Vermont and our contiguous counties and the BlueCard PPO/EPO network nationally or internationally. You must see a network provider or your plan will not cover your care. For more information and how to find a provider, please see page 8. Link to Network page.

6. What if my mental health provider is not in the network?

A member using a provider that is not in the network with have a few options available to them: (a) work with their provider to encourage them to join the network, (b) request transitional visits, or (c) have the provider enter into a single-case agreement for the affected member.

7. What types of doctors are usually considered primary care providers (PCP)?

All members are required to select a PCP. Pediatricians, general practitioners, internists, naturopaths and family practitioners are primary care providers. Some Advanced Practice Registered Nurses may also serve as PCPs. You can find a list of PCPs on BCBSVT's website at **www.bcbsvt.com/findadocto**r. For details on how to use BCBSVT's Find-a-Doctor tool, please see page 8.

8. Are all Vermont primary care providers participating in the BCBSVT network?

Most are. In order to join the network, a primary care provider must apply and be credentialed by BCBSVT. You can always find the most current list of primary care providers in the "Find a Doctor" section of BCBSVT's website at **www.bcbsvt.com/findadoctor**. On that page, choose the BCBSVT Network.

9. Can I designate a different primary care provider for each member of my family?

Yes, each family member may designate a different primary care provider.

10. What if I, or any of my covered dependents, live outside of VT? Do I still need a PCP?

No. The BCBSVT Network has many providers in the contiguous counties in the surrounding states. If you or any of your covered dependents live outside of Vermont, and cannot find a PCP that participates with Blue Cross and Blue Shield of Vermont, you will not be required to select a PCP.

11. In my area, most of the primary care provider practices are closed to new patients. What should I do?

Although the directory of primary care providers lists many provider offices as closed, openings occur from week to week. Consider calling the practice directly to inquire about recent openings. Or use BCBSVT's Find-a-Doctor tool online and select a primary care provider who is accepting new patients.

12. How often can I change my primary care provider?

You may do so as often as once a month. Changes become effective the first of the month following the date BCBSVT receives your request to change.

We encourage you to develop a long-term relationship with your primary care provider. BCBSVT strongly encourages you to provide notice by phone, in writing or on BCBSVT's member resource center by the 15th of the month in order to properly notify your new primary care provider that you will be coming under his or her care for the upcoming month. Please note that we cannot make retroactive changes.

13. When do I need my Primary Care Provider's referral?

It is not necessary for your primary care provider to submit a written referral to BCBSVT. We encourage you to contact your primary care provider before seeking specialty care to ensure you get the correct level of care. Be sure to use a network provider or services will not be covered.

14. Do I need to contact my primary care provider if I need care out of state?

If you are facing a medical emergency, seek care immediately. Contact your PCP as soon as possible afterward to coordinate follow-up care. Such emergencies never require advance approval, although you must notify BCBSVT within 48 hours if you are admitted to the hospital. All plans include a national network and members can see a provider that participates in our Blue Card **EPO/PPO** network.

15. Are adult dependent children covered?

Yes. Generally, dependents can be covered until age 26 regardless if they live at home, are married, employed or away at school.

16. Are dependent children (for example, students) covered for out-of-area care?

Yes, out-of-area care is covered on all four plans. Non-urgent and non-emergency care must be performed by a network Blue Card **PPO/EPO** provider. Urgent or emergency coverage may be sought at any provider.

17. How does my coverage work in emergency situations?

Emergency room care must meet the criteria as defined in your Benefits Description. See page 14 for more details.

It's also wise to inform your primary care provider when you've received emergency care. He or she will want to coordinate necessary follow-up care and ensure you get the appropriate treatment. If you are admitted to the hospital, once you are able to do so, be sure to call BCBSVT for pre-certification to protect you from having to pay for unnecessary and non-covered hospital stays.

18. How does my coverage work in urgent care situations?

Urgent care services must meet the criteria as defined in your Benefits Description. See page 14 for more details.

If you are balanced billed for urgent care services, please call BCBSVT's customer service team at the number listed on the back of your ID card.

19. Are dental services covered under the plan?

Yes, all plans cover limited medical-dental services and bone-impacted wisdom tooth extraction. All plans require you to get prior approval for dental services (prior approval requirement does not apply to bone-impacted teeth). See a sample Benefits Description for details.

20. My daughter just turned 26 and has to be removed from my plan. What are her health plan options?

Vermont Health Connect or other exchange. Your daughter may purchase a product on Vermont Health Connect, the state's health benefits exchange or through a marketplace in the state where she resides. If she lives in Vermont, she may be eligible for premium assistance through the State of Vermont and the federal government.

COBRA. According to COBRA regulations she can select from any of the plan options offered by your employer. She is eligible for coverage for up to 18 months.

21. Are pre-existing conditions covered if I change plans?

BCBSVT does not limit coverage if you, or your dependents have a pre-existing condition.

22. If I cancel my coverage now, can I get back on later?

If you drop coverage now, you can re-enroll during your open enrollment period. Likewise, if you remove your dependents from your coverage, he or she can be added again at open enrollment.

23. May I select from any of the four plans?

Yes, each supervisory union or school district must offer all four plans for all employees to choose from.

24. How is preventive care covered?

Preventive care will now be covered at 100% in all four plans. Preventive services have been defined by the Affordable Care Act. Preventive services are listed by gender and age, based on ACA descriptions. A link to the list of covered services can be found at **www.bcbsvt.com/preventive**. For more information, please see page 10 for details.

25. How are my prescription drugs covered?

That will depend on the plan you choose.

- Prescriptions on the Gold and Silver CDHP plans will be covered the same as your medical benefits, subject to deductible and co-insurance, and to an out-of-pocket limit. (Deductible and co-insurance do not apply to wellness drugs.)
  - These plans have an **aggregate** Prescription Drug out-of-pocket limit. Your prescription costs are capped at $1,350 for an individual-only plan and $2,700 per two-person, parent and child or family plan.
- For the Platinum and Gold plans, you will pay a co-payment or co-insurance depending on the tier-level of the drug. You do not need to meet a deductible.
  - These plans have a **stacked** Prescription drug out-of-pocket limit. Therefore, your prescription costs are capped at $1,300 per individual and $2,600 (shared) per two-person, parent and child or family plan.
- Diabetic prescriptions and testing supplies purchased at the pharmacy, on any of the plans, will continue to be paid at 100% by VEHI.

26. How do I know what tier my prescription drug is in?

BCBSVT and VEHI will provide you with the means to identify the list of Tier 1 vs Tier 2 generics, as well as the preferred brand-name prescriptions, via the BCBSVT website at **www.bcbsvt.com/rxcenter**.

Notice of privacy practices

How BCBSVT protects your privacy

We are required by law to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You have the right to gain access to your health information and to information about BCBSVT's privacy practices.

In general, BCBSVT's notice of privacy practices explains:

- BCBSVT's routine use and disclosure of personal health information (PHI);
- The internal protection of oral, written and electronic PHI; and
- The protection of information disclosed to plan sponsors or to employers.

A complete copy of BCBSVT's Notice of Privacy Practices is available at **www.bcbsvt.com/privacypolicies**. Or to request a paper copy, contact BCBSVT's customer service team at the phone number listed on the back of your ID card

How VEHI protects your privacy and security

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

You have received this notice because you receive medical and/or dental insurance coverage under a health benefits plan offered by the Vermont Education Health Initiative ("VEHI") and/or you participate in VEHI's wellness programs. VEHI is an inter-municipal insurance association that is approved and overseen by the Vermont Department of Financial Regulation. VEHI offers non-insured, self-funded health benefit plans, wellness programs and compliance services to schools and other educational organizations in Vermont. The enrollees of VEHI's health benefits plan are active and retired school employees and their dependents. VEHI's health benefit plans are financed by employer and/or employee contributions.

This notice refers to VEHI by using the terms "us," "we" or "our."

Generally, "protected health information" or "PHI" is information that relates to your past, present or future physical or mental health or condition (including your genetic information, as defined by federal law) the provision of health care to you or the payment for that health care, and that identifies you or with respect to which there is a reasonable basis to believe that the information can be used to identify you.

This notice describes our privacy practices, which include how we may use and disclose your protected health information. We are required by certain federal and state laws to maintain the privacy of your PHI. We also are required by the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") developed by the Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to give you this notice of our privacy practices and legal duties and your rights concerning your PHI.

Use and disclosure of your protected health information (PHI)

The following categories describe the different ways in which we may use and disclose your protected health information. Please note that every permitted use or disclosure of your PHI is not listed below. However, the different ways we will, or might, use or disclose your PHI do fall within one of the permitted categories described below.

To make or obtain payment.

We may use or disclose your protected health information to make payment to or collect payment from third parties, such as other health plans or health care providers, for the care you receive. For example, we may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits or we may use your PHI to pay claims for services provided to you by doctors or hospitals which are covered by your health plan.

To conduct health care operations.

We may use or disclose your protected health information for our operations, to facilitate our administration and as necessary to provide coverage and services to all of our participants. These activities may include:

- quality assessment and improvement activities;
- activities designed to improve health care or reduce health care costs;
- clinical guideline and protocol development, case management and care coordination;
- contacting health care providers and participants with information about treatment alternatives and other related functions;
- competence or qualifications reviews and performance evaluations of health care professionals;
- accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits, provided that we are prohibited from using or disclosing your protected health information that is genetic information, as defined by federal law, for such purposes;
- review and auditing, including compliance reviews, medical reviews, legal services and compliance programs;
- business planning and development including cost management and planning related analyses and formulary development; and
- business management and general administrative activities, including customer service and resolution of internal grievances.

For example, we may use and disclose your protected health information to conduct case management, quality improvement, utilization review and provider credentialing activities or to engage in customer service and grievance resolution activities. We may also use and disclose your PHI to determine the types of wellness programs we may offer and to offer those wellness programs to you and, with your written authorization, to advocate on your behalf.

For treatment purposes.

We may disclose your protected health information to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, we may disclose your PHI to doctors who request medical information from us to supplement their own records.

To plan sponsors.

Plan sponsors are employers or other organizations that sponsor a group health plan.

We may disclose your protected health information to the plan sponsor of your group health plan. For example:

- We may disclose "summary health information" to the plan sponsor of your group health plan to use to obtain premium bids for providing health insurance coverage or to modify, amend or terminate its group health plan. "Summary health information" is information that summarizes claims history, claims expenses or types of claims experienced by the individuals who participate in the plan sponsor's group health plan.
- We may disclose your PHI to the plan sponsor of your group health plan to verify enrollment or disenrollment in your group health plan.
- If the plan sponsor of your group health plan has met certain requirements of the Privacy Rule, we may disclose your PHI to the plan sponsor of your group health plan so that the plan sponsor can administer the group health plan. The plan sponsor of your group health plan may be your employer. You should talk to your employer to find out how your employer might use this information.

For treatment alternatives.

We may use and disclose your protected health information to tell you about or recommend possible treatment options or alternatives that may interest you.

For distribution of health-related benefits and services.

We may use or disclose your protected health information to provide you with information on health-related benefits and services that may interest you.

When required by law.

We will disclose your protected health information when we are required to do so by any federal, state or local law. For example, we may be required to disclose your PHI if the Department of Health and Human Services investigates our HIPAA compliance efforts.

To conduct health oversight activities.

We may disclose your protected health information to health oversight agencies for their authorized activities including audits, civil administrative or criminal investigations, inspections and licensure or disciplinary actions.

In connection with public health activities.

We may disclose your protected health information to public health agencies for public health activities that are permitted or required by law, such as to:

- prevent or control disease, injury or disability;
- maintain vital records, such as births and deaths;
- report child abuse and neglect;
- notify a person about potential exposure to a communicable disease;
- notify a person about a potential risk for spreading or contracting a disease or condition;
- report reactions to drugs or problems with products or devices;
- notify individuals if a product or device they may be using has been recalled; and
- notify appropriate government agencies and authorities about the potential abuse or neglect of an adult patient, including domestic violence.

In connection with judicial and administrative proceedings.

As permitted or required by state or other law, we may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.

For law enforcement purposes.

As permitted or required by state or other law, we may disclose your protected health information to law enforcement officials for certain law enforcement purposes, including, but not limited to, if we have a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the event of a serious threat to health or safety.

We may, consistent with applicable law and ethical standards of conduct, disclose your protected health information if we, in good faith, believe that disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For specified government functions.

In certain circumstances, federal regulations require us to use or disclose your protected health information to facilitate specified government functions related to the military, veterans affairs, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For workers' compensation.

We may release your protected health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

Notice of privacy practices (cont'd)

For research.

We may use or disclose your protected health information for research purposes, subject to strict legal restrictions.

To you.

Upon your request and in accordance with applicable provisions of the Privacy Rule, we may disclose to you your protected health information that is in a "designated record set." Generally, a designated record set contains enrollment, payment, claims adjudication and case or medical management records we may have about you, as well as other records that we use to make decisions about your health care benefits. You can request the PHI from your designated record set as described below in the section titled "Your Rights with Respect to Your Protected Health Information."

To our business associates.

We may disclose your protected health information to contractors, agents and other business associates of ours who need the information to provide services to us, for us or on our behalf. When we disclose your PHI in this manner we obtain a written agreement that our business associate will protect the confidentiality of your PHI.

Authorization to use or disclose your protected health information

Other than as stated above, and as otherwise permitted by applicable law, we will not use or disclose your protected health information other than with your written authorization. You may give us a written authorization permitting us to use or disclose your PHI for any purpose, including any marketing or sale of PHI that is permitted by law. We will not sell you PHI, or use or disclose it for marketing purposes, without your written authorization.

You may revoke an authorization that you provide to us at any time. Your revocation must be in writing. After you revoke an authorization, we will no longer use or disclose your protected health information for the reasons described in that authorization, except to the extent that we have already relied on the authorization.

Your rights with respect to your protected health information

You have the following rights regarding your protected health information that we maintain:

Right to request restrictions.

You have the right to request that we restrict certain uses and disclosures of your protected health information. You have the right to request a limit on our use or disclosure of your PHI in connection with your treatment, payment for your care and our health care operations. We are not required to agree to your request. If we do agree to your request, we will be bound by our agreement except in emergency situations and as otherwise required by law. If we do not agree to a request, we are required to give you notice. An agreed to restriction continues until you terminate the restriction (either orally or in writing) or until we inform you that we are terminating the restriction. If you wish to request a restriction, please contact our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602, by fax at (802) 229-1446 or by telephone at (802) 223-5040.

Right to receive confidential communications.

You have the right to request that we communicate with you in a certain way if you feel the disclosure of your protected health information could endanger you. For example, you may ask that we only communicate with you by mail, rather than by telephone, or at work, rather than at home. If you wish to receive confidential communications, please make your request in writing to our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602 or by fax at (802) 229-1446. Your written request must clearly state that the disclosure of all or part of your PHI could endanger you. We will make every reasonable effort to honor your requests for confidential communications.

Right to inspect and copy your protected health information.

You have the right to inspect and copy your protected health information contained in a "designated record set," other than psychotherapy notes and certain other information. Generally, a designated record set contains enrollment, payment, claims adjudication and case or medical management records we may have about you, as well as other records that we use to make decisions about your health care benefits. A request to inspect and copy records containing your PHI must be made in writing to our Privacy Officer by mail at

52 Pike Drive, Berlin, Vermont 05602 or by fax at (802) 229-1446. If you request a copy of your PHI, we may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to amend Your protected health information.

If you believe that any of your protected health information contained in a "designated record set" is inaccurate or incomplete, you have the right to request that we amend the PHI. Generally, a designated record set contains enrollment, payment, claims adjudication and case or medical management records we may have about you, as well as other records that we use to make decisions about your health care benefits. The request to amend may be made as long as we maintain the information. A request for an amendment of records must be made in writing to our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602 or by fax at (802) 229-1446. We may deny the request if the request does not include a reason to support the amendment. We may also deny the request if we did not create your PHI records, if the PHI you are requesting to amend is not part of the designated record set, if you are not permitted to inspect or copy the PHI you are requesting to amend, or if we determine the records containing your PHI are accurate and complete. If we deny your request, you have the right to submit a written statement of disagreement.

Right to an accounting.

You have the right to request an accounting of certain disclosures of your protected health information we have made or that were made on our behalf. Any accounting will not include certain disclosures, including, without limitation:

- disclosures to carry out treatment, payment or health care operations;
- disclosures we made to you;
- disclosures that were incident to another use or disclosure; and
- disclosures which you authorized.

The request for an accounting of disclosures must be made in writing to our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602 or by fax at (802) 229-1446. The request should specify the time period for which you are requesting the information. Accounting requests may not be made for periods of time going back more than six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests in a 12-month period may be subject to a reasonable cost-based fee. We will inform you in advance of the fee, if applicable.

Right to a paper copy of this notice.

You have the right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive this Notice electronically. To obtain a paper copy, please contact our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602, by fax at (802) 229-1446 or by telephone at (802) 223-5040. You also may obtain a copy of the current version of our Notice at our website, **www.vehi.org**.

Right to file complaints.

You have the right to file complaints with us if you believe that your privacy rights have been violated. Any complaints to us should be made in writing to our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602 or by fax at (802) 229-1446. We encourage you to express any concerns to us that you may have regarding the privacy of your information. You also may complain to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. We will not retaliate against you in any way for filing a complaint against us or with the Secretary of the Department of Health and Human Services.

Appointment reminders and fundraising

We may call you to remind you of appointments. Please inform us if you do not wish to be called. We may also provide your contact information (name, address, and phone number) and the dates you received services from us to others in connection with our fundraising efforts. You have the right to opt-out of our use of your contact information in connection with our fundraising efforts. If you wish to opt-out, please inform us and we will respect your wishes.

Our duties with respect to your protected health information

We are required by law to maintain the privacy of your protected health information as set forth in this Notice and to provide you this Notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice, which we may amend from time to time. We are also required by law to notify you if the event of any breach of the privacy of your PHI and to accommodate reasonable requests by you to communicate health information to you by alternative means and /or at alternative locations.

We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. If we materially change this Notice we will provide a copy of the revised Notice to you within 60 days of the change.

Potential impact of state law

In some situations, we may choose or be required to follow state privacy or other applicable laws that provide greater privacy protections for your protected health information. If a state law requires that we not use or disclose certain of your PHI, then we will use or disclose that PHI according to applicable state law.

Contact person

We have designated our Privacy Officer as the contact person for all issues regarding participant privacy and your privacy rights, including any further information about this Notice. You may contact this person by mail at 52 Pike Drive, Berlin, Vermont 05602, by fax at (802) 229-1446 or by telephone at (802) 223-5040.

Effective date

This Notice is effective September 1, 2013, with non-material revisions on May 1, 2017.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, OR DESIRE MORE INFORMATION ABOUT THIS NOTICE, PLEASE CONTACT OUR PRIVACY OFFICER BY MAIL AT 52 Pike Drive, Berlin, Vermont 05602, BY FAX AT (802) 229-1446 OR BY TELEPHONE AT (802) 223-5040.

Contact BCBSVT or VEHI

Always call customer service at BCBSVT first when you need help with your health plan. For your convenience, we list frequently used phone numbers, addresses and websites at the right. Feel free to contact us in any of the following ways when you need information.

MAIL

Blue Cross and Blue Shield of Vermont
P.O. Box 186 | Montpelier, VT 05601-0186

Vermont Education Health Initiative
52 Pike Drive | Berlin, VT 05602

PHONE

BCBSVT Customer Service.....(800) 247-2583

VEHI.....(802) 223-5040

Vermont–National Education Association .....(802) 223-6375

Vermont School Boards Insurance Trust .....(802) 223-5040

Pharmacy Network .....(877) 493-1949

Case management/ prior approval .....(800) 922-8778

WEBSITES

Blue Cross and Blue Shield of Vermont:
www.bcbsvt.com

Vermont Education Health Initiative:
www.vehi.org

Pharmacy Network:
www.express-scripts.com

HSA/HRA information
www.healthequity.com/learn

IN PERSON

Blue Cross and Blue Shield of Vermont

Berlin Office
445 Industrial Lane (off Airport Road)
Berlin, VT 05602
Hours: M-F; 8 a.m.–4:30 p.m.

OR

Information and Wellness Center

The Blue Mall
150 Dorset St.
South Burlington, VT 05403
(802) 764-4828
Hours: M-F; 8 a.m.–4:30 p.m.

vehi

VEHI's health benefit plans are administered by:

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Phone: (800) 247-2583 | *Email:* customerservice@bcbsvt.com

www.bcbsvt.com

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