

Benefits of the
**Vermont
Education
Health
Initiative**

VEHI's health benefit plans are administered by:



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 VEHIs 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 Blue Cross administration of the program and state and federal taxes, assessments and fees. The remaining one percent funds VEHIs wellness program and administrative costs.

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



Dear School Employees,

We are committed to providing a range of employee health 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 you, 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, as well as a beneficiary of insurance. We also believe that when you are involved directly in making medical decisions with your provider, you are better able to ensure that you will receive high-quality services and products that are clinically recommended and affordable. Vermont schools, taxpayers, VSTRS and school employees, active and retired, all benefit when health care services are delivered smartly, equitably and affordably.

Sincerely,
VEHI Management Team

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. For detailed information, you can consult your specific Summary of Benefits and Coverage (SBC), SBC Wrap, the Benefits Description Document (BDD) and BDD Wrap from your employer, or find samples at vehi.org.

Once you enroll, you can access the plan documents on the Member Resource Center at bluecrossvt.org/member-logins.

Your plan documents consist of your:

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

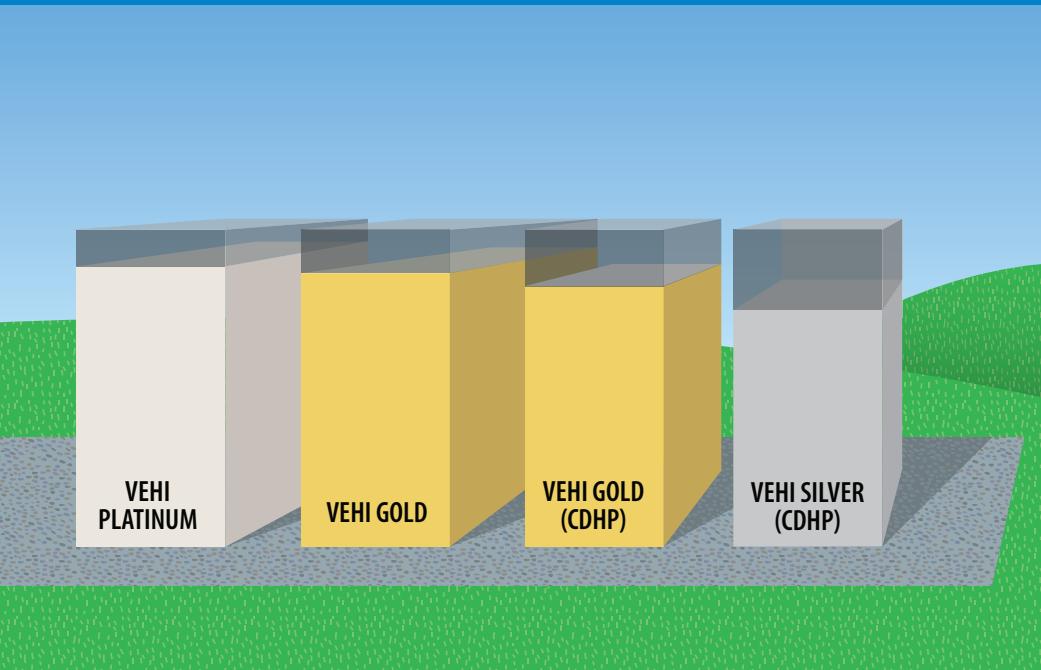
In the event of any discrepancies between this document and your plan documents, your plan documents prevail.

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VEHI COVERAGE



VEHI'S FOUR HEALTH PLANS:

- **VEHI Platinum:** see page 22
- **VEHI Gold:** see page 24
- **VEHI Gold CDHP:** see page 28
- **VEHI Silver CDHP:** see page 30

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 22-23)
- a calendar-year deductible and cost-sharing (starts on January 1)
- the largest, most extensive network of providers within Vermont and the U.S., partnering with approximately 90 percent of doctors and hospitals nationwide to provide high-quality care at the best possible price
- 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 Blue Cross's network area, you are not required to select a PCP.



*CDHP: Consumer
Directed Health Plan*



- access to doctors and hospitals in more than 190 countries and territories around the world through the Blue Cross Blue Shield Global® Core 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 Blue Cross's website bluecrossvt.org
- state-of-the-art wellness programming offered by VEHI PATH and Blue Cross, featuring online tools, face-to-face discussions and much more tomypath.com
- certain preventive care services, at no cost to you
- the Blue HealthSolutions™ program, including health management features such as our maternity support program, 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, see page 20-21.)
- 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 bluecrossvt.org/telemedicine for general consultative services such as
 - colds and flu
 - sinus, ear and eye infection
 - headaches
 - allergies
 - nutritional counseling
 - breastfeeding support; and
 - behavioral health services.
- one routine vision exam per member, per calendar year for a \$20 co-payment.

MEMBERSHIP INFORMATION



Eligibility

You must be an active employee of a school district or supervisory union to be eligible for enrollment and work a minimum of 17.5 hours per week during the school year.

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 Blue Cross receives your request before this date, they will make the change effective on the open enrollment date. If Blue Cross 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 group benefits manager.

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

Marriage

Blue Cross must receive your marriage notification within 60 days following your marriage. If Blue Cross 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 Blue Cross receives your request more than 31 days after the date of your marriage, your new membership begins the first day of the month after Blue Cross 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).

Blue Cross must receive your request for adding a dependent Child to continue benefits for the Child past 60 days. If Blue Cross 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.
- you will be subject to cost-sharing for your newborn's Covered services beginning on their date of birth, whether or not you add your newborn to coverage permanently.

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

Ending coverage

Your coverage will end on the last day of the month after any of these events occur:

- loss of employment
- divorce, dissolution of civil union
- death
- dependent turning age 26

You may have the right to continue your coverage through COBRA. Please contact your group benefits manager for full details.

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's child medical support order law, the effective date will be three days after you mail the court order to Blue Cross or when Blue Cross receives the court order, whichever is sooner. If the court order specifies a different effective date, Blue Cross will use that date. Blue Cross 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 Blue Cross'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 group benefits manager with any questions or concerns regarding you or your dependent's eligibility.

Accumulator credit

If you change districts during a calendar year, VEHI allows you to transfer what you paid in deductibles, co-payments and co-insurance on your

health plan with the first district to be transferred to your health plan with the second district for the remainder of the same calendar year. This is called "accumulator credit," which also includes visit limits for certain services, such as chiropractic care.

There are some limitations and requirements that apply. For more details, please visit vehi.org.

Should you lose or have your ID card stolen, please call Blue Cross Customer Service at (800) 344-6690 as soon as possible.



FINDING A DOCTOR

Finding a Blue Cross network provider

You can find network providers for all your needs at bluecrossvt.org/find-doctor, including providers and hospitals in the Vermont service area, National and International providers and hospitals, as well as network pharmacy, vision and telemedicine providers.

Finding a network provider is easy.

- Visit bluecrossvt.org/find-doctor to find a provider in Vermont or contiguous counties.
- Traveling out of state or abroad, visit provider.bcbs.com.
- To understand your network requirements, please refer to the chart below. If you have questions, call Blue Cross's customer service team at (800) 344-6690 or the national provider finder line at (800) 810-BLUE (2583).

Even if 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.

Primary care provider (PCP) requirement

You must select a primary care provider (PCP) for each covered family member in order to enroll—except if you or your dependent reside outside of the Blue Cross network area (Vermont and contiguous counties).

Selecting a primary care provider (PCP)

To select a primary care provider (PCP) follow the steps, in the previous column to find a doctor online and check the PCP box in the "Providers and Hospitals in Vermont Service Area" 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.

Finding national providers and providers around the globe

Use the National Doctor and 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.

1. Go to provider.bcbs.com
2. Type in the VEI (your alpha prefix) that appears in front of your member number on your ID card.

Your three-digit alpha prefix signifies that your provider network will be the BlueCard® PPO/EPO network.

If you have questions, you may call Blue Cross's customer service team at (800) 344-6690 or the BCBS National Doctor and Hospital Finder at **(800) 810-BLUE (2583)**.

You can print out your results from either the Blue Cross Find a Doctor tool or the National Doctor and Hospital Finder. The Blue Cross customer service team can send you a paper print, if you do not have access to a computer or printer. Both electronic and paper directories give you information on provider qualifications, such as training and board certification.

Understanding your networks

PCP required	Yes, but you do not need a referral to see a specialist.
Network care	Use our Blue Cross network providers in Vermont and contiguous counties, as well as our national BlueCard® PPO/EPO network.
Non-network care	You must get prior approval for all non-network care. Non-network care is care you receive from a provider who is not in the Blue Cross network or the national BlueCard® PPO/EPO network.
Emergency or urgent care	In these situations, please seek care immediately. If a network or non-network provider charges you any balance between the provider's charge and what the plan pays for emergency or urgent care services—please call Blue Cross's customer service team at (800) 344-6690.
Finding a Local Vermont provider	To find a Blue Cross provider visit bluecrossvt.org/find-doctor or call Blue Cross's customer service team at (800) 344-6690.
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).



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.

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.

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.

Please note: If a network or non-network provider charges you any balance between the provider's charge and what the plan pays for emergency or urgent care services—please call Blue Cross's customer service team at (800) 344-6690.

	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 services 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.

Your local urgent care center

Make sure you are aware of an urgent care center in your area, and that it is part of the Blue Cross network or the national Blue Card PPO/EPO network.

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.

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:

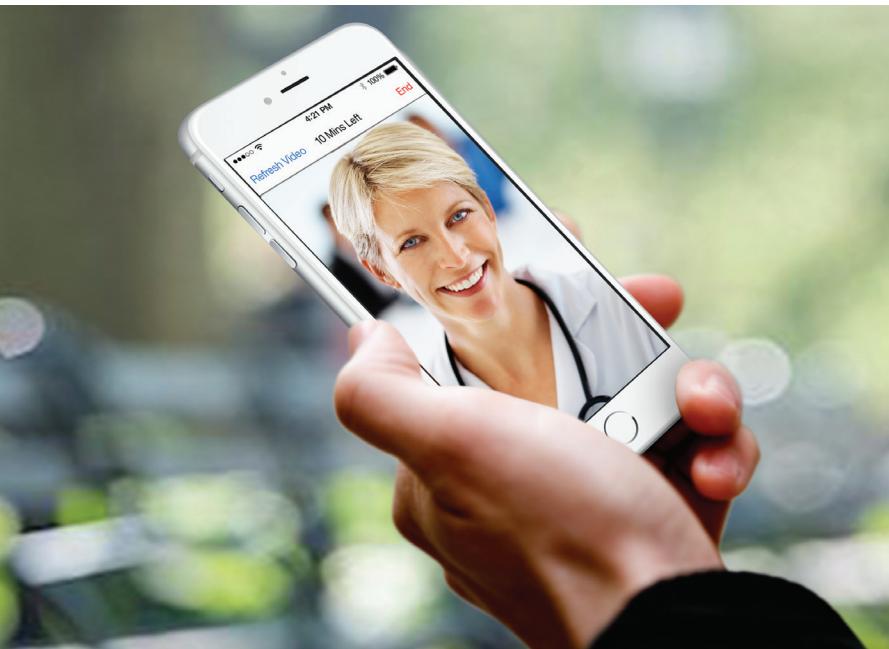
- a condition that places the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

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

In an emergency, you need care right away. 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.

TELEMEDICINE

A faster, easier way to see a provider. Sick on a weekend? Advice from a leading provider is as close as your computer, tablet or smart phone. Blue Cross and Blue Shield of Vermont provides access to convenient telemedicine services with a nationally acclaimed telemedicine vendor, to provide you with telemedicine services 24/7, wherever you are.



You can use Telemedicine when:

- You need to see a provider, but can't fit it into your schedule
- Your provider's office is closed
- You feel too sick to leave the house
- You are caring for someone and cannot leave the house

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

What is telemedicine?

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

- | | |
|------------------------------|-----------------------------|
| ▪ nutritional counseling | infections |
| ▪ breastfeeding support | ▪ pharyngitis |
| ▪ behavioral health services | ▪ rashes |
| ▪ respiratory infections | ▪ pink eye |
| ▪ bronchitis | ▪ cough |
| ▪ urinary tract | ▪ flu |
| | ▪ stuffy nose or congestion |
| | ▪ allergies |

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

Helpful tips

• Register before you get sick!

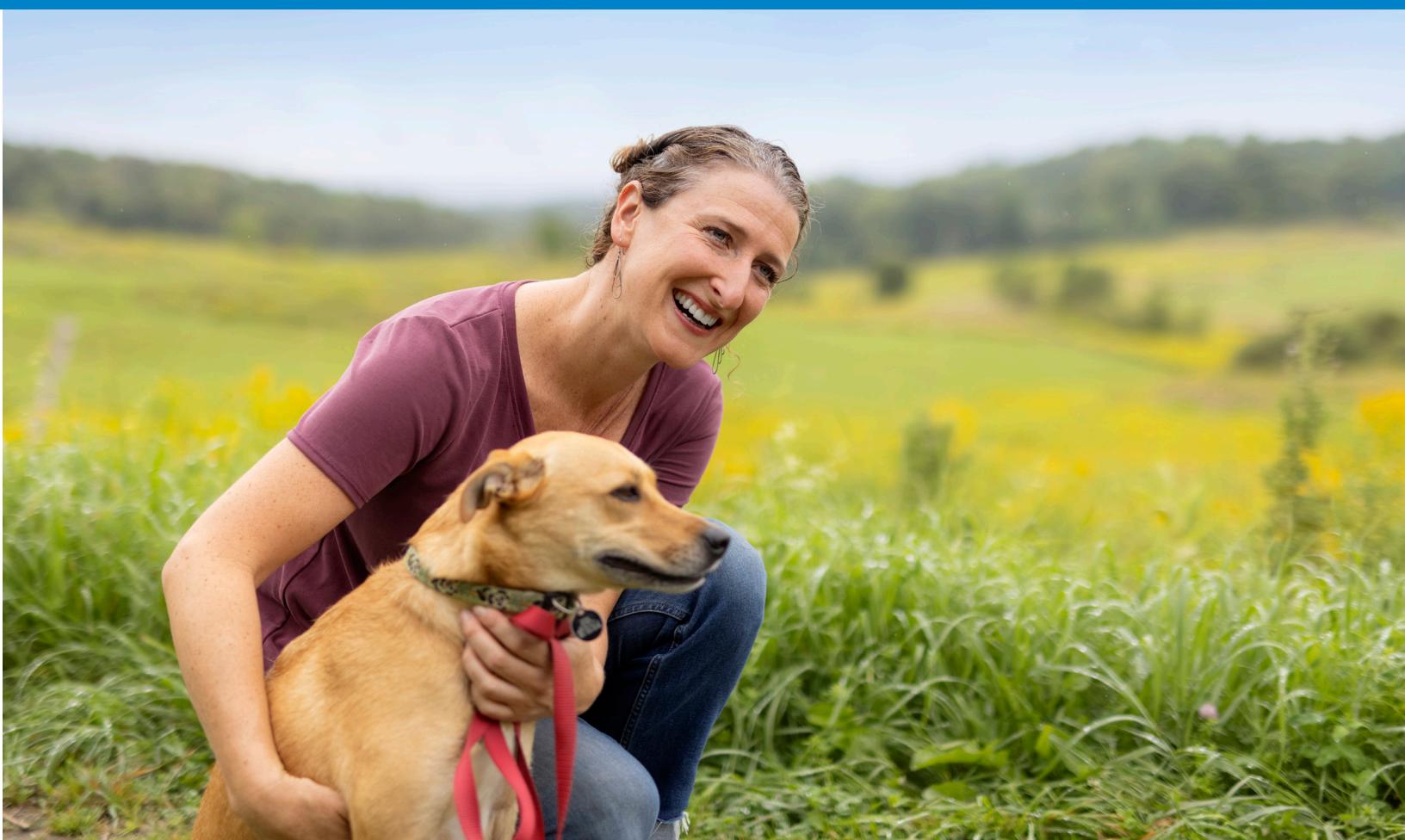
This way, when illness hits, you are merely a finger tap away from getting the care you need. Visit blucrossvt.org/telemedicine to register.

• After any telemedicine visit, follow up with your primary care provider's office

Keeping your primary care provider informed helps your provider manage your health.

• 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 primary care provider's office and your closest urgent care facility 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.



Community Programs and Events

Throughout the year, Blue Cross hosts signature events that are focused on helping Vermonters get outside each season and experience the beauty of Vermont. From Snow Days to Hike, Bike & Paddle, these signature events are free and fun for everyone!

Learn more at bluecrossvt.org/health-community.

Student Loan Services

Your financial wellness is an important part of your overall health and wellbeing. Blue Cross has partnered with GradFin to provide student loan services to VEHI members.

To learn more, visit Blue Cross's health and community page at goto.gradfin.com/bcbsvt/.

Stay on Top of Your Health with Text Alerts

You can now receive personalized, secure updates from Blue Cross, right to your cell phone. Text alerts allow for quick access to your personal information, so you can understand your benefits and get the most out of your health plan.

Learn more at bluecrossvt.org/text-alerts.

PREVENTIVE CARE

What is preventive care?

The term "preventive care" refers to health care services meant to help you avoid serious medical problems through routine care and screening.

Some preventive care services help identify a health issue before it becomes very serious—like your cholesterol test. Some preventive care services help prevent a health issue before it happens—like your annual flu shot.

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). The plan 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. The plan also covers certain women's health services, vaccines and 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 the plan covers 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.

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.

For a more detailed description of preventive care, including charts that list medications and much more, visit bluecrossvt.org/preventive.

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

Service	Examples/restrictions
Aspirin	Adults, ages 50–59, with a 10% or greater risk of cardiovascular disease (generic only)
Contraception	Available as prescribed to prevent pregnancy for all persons with reproductive capacity (generic only for oral contraceptives)
Folic acid supplements	All who are capable of or planning for pregnancy (generic only)
Fluoride supplements	Children, ages 6 mos.–5 years (generic only)
Statins	Adults ages 40–75, without a history of cardiovascular disease (generic only)
Tobacco cessation	Nicotine replacement products, Bupropion (up to 180-day supply, generic only)

These examples are subject to change—please consult bluecrossvt.org/preventive or call Blue Cross customer service for full details.



Understanding your prenatal coverage

Your plan covers OB-GYN office visits and childbirth and delivery services.

The Blue Cross customer service team can also help you plan for the arrival of your new baby and understand your cost-sharing responsibilities. Please call (800) 344-6690.

Members enrolled in our Better Beginnings® program receive extra benefits.

If you're interested in learning more about Blue Cross' Better Beginnings Program, see page 32 for details or call (800) 922-8778.

For prenatal care on the Platinum and Gold plans, a \$25 co-payment applies to the first office visit to confirm pregnancy. After confirmation of pregnancy, most routine provider fees for prenatal and postnatal care, management of labor and delivery, and other care related to your pregnancy are covered by one additional \$25 co-payment¹. In most cases, when using one network provider, you may not be billed for routine prenatal 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 prenatal care on the Gold CDHP and Silver CDHP, the first office visit to confirm pregnancy is subject to deductible and co-insurance. After confirmation of pregnancy, all routine provider fees for prenatal 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. However, after the first confirmation visit, when using one network provider, you generally won't be billed for routine prenatal 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 prenatal 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.

You will be subject to cost-sharing for your newborn's Covered services beginning on their date of birth, whether or not you add your newborn to coverage permanently.

¹ To learn the prenatal services included in this co-payment, please contact Blue Cross customer service at (800) 344-6690.

Preventive care during and after pregnancy

The table on the right is a general reference guide of preventive care screenings that may be factored into preventive care screenings, exams and medicines. This additional care may require cost-sharing. For full details, please see the *preventive care guide for you and your family* available at bluecrossvt.org/preventive.

Federal and state regulators recommend certain screenings for pregnant persons. If you have questions at any point, consult your provider or call Blue Cross's customer service team at (800) 344-6690.

General preventive care guidelines*		
Infectious disease	Asymptomatic Bacteriuria	Screening recommended at 12-16 weeks gestation or at first prenatal visit, if later.
	Gonorrhea	Screening recommended at first prenatal visit for age 24 or younger and for pregnant persons at increased risk.
	Hepatitis B Virus	Screening recommended at first prenatal visit.
	Syphilis infection	Screening recommended at first prenatal visit.
Obstetric conditions	Rh (D) incompatibility	Screening recommended at first prenatal visit.
	Support	Recommended lactation counseling as needed.
	Supplies	You must get Prior Approval for hospital-grade breast pumps.
Other screenings	Alcohol and drug misuse	Recommended screening for all pregnant persons.
	Depression	
	Gestational diabetes	Screening recommended by glucose test for persons at 24 to 28 weeks pregnant.

* These are general guidelines. Please consult your provider or call Blue Cross's customer service team at (800) 344-6690.

PHARMACY PROGRAMS



As a VEHI member, you will get your prescription drugs through Blue Cross'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. Most major chains (Rite-Aid, Kinney, Walgreens, CVS, etc.) and a large percentage of pharmacies nationwide currently belong to this network. Visit blucrossvt.org/find-doctor or call (877) 493-1949 for a list of network pharmacies.

For all plans

The VEHI plans follow the Vermont Blue Rx National Performance Formulary (NPF). You can see the medications currently on the NPF by visiting our Vermont Blue Rx Resource Center, blucrossvt.org/vtbluerx.

VEHI does not provide coverage for drugs designed to treat erectile dysfunction and infertility. Please note that services to determine a couple's infertility will be covered.

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.

VEHI Platinum and Gold Drug Coverage:

To understand what you will pay if you choose the VEHI Platinum or Gold plan, please see the charts starting on page 22.

VEHI is among the first of Blue Cross 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 covers medicines for diabetes at 100 percent. For more information regarding diabetic supplies and medications, please see page 16.

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 28. 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 offers 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. For the most recent copy, visit our Vermont Blue Rx Center at blucrossvt.org/vtbluerx.



The VEHI plans follow Vermont Blue Rx National Performance Formulary (NPF). You can see the medications that are currently on the NPF by visiting our Vermont Blue Rx Resource Center, bluecrossvt.org/vtbluerx.

Drug list updates

The National Performance Formulary (NPF) can 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.

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 our Vermont Blue Rx Resource Center.

Benefit exceptions for excluded medications

If you are currently using a medication that is excluded from the National Performance Formulary, your provider may request a benefit exception after you enroll.

Specialty medications

If you take specialty medications, you must get your medications through one of our Exclusive Specialty Pharmacy Network locations. Prior authorization is required. For more information, visit our Vermont Blue Rx Resource Center or call (877) 493-1949 to speak with a patient-care representative.

Convenient refills and savings with home delivery program

If you use prescription drugs on an ongoing basis, Vermont Blue Rx home delivery service may be a less expensive, more convenient way for you to buy prescriptions. To begin using the Vermont Blue Rx home delivery service for your maintenance drug, register at our Vermont Blue Rx Resource Center.

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

Prior approval

Blue Cross's prior approval list changes periodically. The most current list is found online or by calling Vermont Blue Rx (see blue box, below right). Prior approval is required for drugs that have been on the market less than 12 months and/or medications without National Drug Code numbers.

Quantity limits

If your doctor prescribes a drug in an amount that exceeds certain criteria, such as the manufacturer's recommendations, Blue Cross may ask for documentation.

Step therapy

Blue Cross'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.

Lifestyle and Medication Guidance

Blue Cross offers one-on-one consultations, either in person or via telehealth, with a pharmacist who can help you focus on a holistic health approach, provide education, support, and personalize recommendations for your individual needs. Contact Blue Cross to schedule your free confidential consultation: (802) 371-3660.

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 (DME) supplier, but they are subject to your deductible and co-insurance if you are on a CDHP. If you need help managing this condition or would like a nurse to assist with addition education and information, see pages 32-33.

	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	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	Covered at 100 percent	Covered at 100 percent	Deductible, then co-insurance	Deductible, then co-insurance

Not all care related to diabetes is covered at no cost. Certain supplies and equipment, even when used in conjunction with diabetes treatment, will apply cost-share. Examples include sterile wipes, glues and adhesives. Call Blue Cross customer service (800) 344-6690 to discuss coverage and benefits.



Blue Cross's prior approval program

To keep costs down and to help you get care in the most convenient and cost-effective settings, Blue Cross'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.
- Blue Cross lists some 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 bluecrossvt.org/priorapproval or call Blue Cross customer service at (800) 344-6690.

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 Blue Cross's Member Resource Center online. To learn more about Blue Cross' Member Resource Center, see page 18. (If you would like a hard copy, please call Blue Cross customer service at (800) 344-6690.) Please read your Benefits Description carefully; it is a part of your plan documents which govern your benefits.

WEB RESOURCES

The screenshot shows the VEHI website at <http://vehi.org>. The header includes the VEHI logo, navigation links for About Us, Benefits, Wellness Program, Retirees, and Board. Below the header is a large photo of a person walking away on a path. The main content area is titled "Employee Resources" and features a grid of icons for various benefit topics like "How Do I Know What To Pay?", "Health Care Spending Accounts", and "Your Health Plan Documents". A "Related Pages" sidebar on the right lists Employee Resources, Employee Benefits, and Benefits Guide.



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, the PATH wellness program and how to contact us.

For more information about VEHI's wellness program, PATH, please see page 34.



The screenshot shows the Blue Cross BlueShield of Vermont website at <http://www.bluecrossvt.org>. The header includes links for Members, Providers, Employers, Brokers, and About. A "Log In or Pay Bill" button is highlighted with a red oval. The main content area features a headline "Stay on top of your health with text alerts" and a subtext explaining the combination of simplicity of text messaging with the security of a mobile web page. A "Find Out More" button is present. To the right is a photo of a person holding a smartphone displaying a text message with a blue envelope icon.

Blue Cross' secure member resource center

From Blue Cross' home page, you may log into the secure member site, where you can:

- check claims status
- review your Summary of Health Plan Payments (SHPP) for accuracy and report any discrepancies
- 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
- use secure e-mail to ask questions and hear back within one business day
- use Healthcare Advisor to compare cost and quality data on a variety of providers, services and supplies
- order ID cards

To gain entry to the member site, visit bluecrossvt.org/member-logins.

- You will need your member identification card to register.
- You must enter your information in a specific format. Review the graphic on the website for help or call customer service.

UNDERSTANDING COST-SHARING TERMS



This page explains the common cost-sharing terms. Not all terms listed below apply to all plans.

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.

If you use a non-network provider for non-emergency care, you may be billed the difference between the allowed amount and the provider's billed charges.

The difference between the allowed amount and your provider's billed charges does not accumulate toward your calendar year out-of-pocket limit and you are responsible for paying the difference.

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 plan you choose), you may pay co-insurance for certain drugs until you meet your Prescription Drug out-of-pocket limit.

What is the allowed amount?

The allowed amount is the amount VEHIC 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. Often, your provider will charge more than the allowed amount for covered services.

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.

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 VEHIC 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, which may include co-payments or co-insurance.

What is an aggregate deductible?

If your VEHIC 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 VEHIC 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 VEHIC 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 VEHIC 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 VEHIC 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 VEHIC 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.

VEHI PLAN COMPARISON

	VEHI PLATINUM	VEHI GOLD
Types of Services	Deductible	Deductible
medical deductible (individual/family)	\$500 / \$1,000 stacked^	\$1,200 / \$2,400 stacked^
prescription drug deductible	\$0	\$0
medical out-of-pocket limit (individual/family)	\$1,500 / \$3,000^	\$1,800 / \$3,600^
prescription drug out-of-pocket limit (individual/family)	\$1,300 / \$2,600^	\$1,300 / \$2,600^
TOTAL out-of-pocket exposure for both medical and prescription drug benefits (individual/family)	\$2,800 / \$5,600	\$3,100 / \$6,200
Service Categories	Co-payment/Co-insurance	Co-payment/Co-insurance
preventive care	\$0	\$0
primary care office visit	\$25	\$25
mental health/substance abuse office visit	\$25	\$25
specialist office visit	\$35	\$35
urgent care	\$75	deductible, then 20% co-insurance
emergency room	\$250	deductible, then 20% co-insurance
ambulance	deductible, then 20% co-insurance	deductible, then 20% co-insurance
durable medical equipment (DME)	deductible, then 20% co-insurance	deductible, then 20% co-insurance
radiology (MRI, CT, PET)	deductible, then 20% co-insurance	deductible, then 20% co-insurance
outpatient care	deductible, then 20% co-insurance	deductible, then 20% co-insurance
inpatient care, general hospital	deductible, then 20% co-insurance	deductible, then 20% co-insurance
routine vision exam with a VSP provider	\$20	\$20
Service Categories	Co-payment/Co-insurance	Co-payment/Co-insurance
wellness drugs #	n/a	n/a
generic tier 1	\$4 (30-day supply)	\$4 (30-day supply)
generic tier 2	\$10 (30-day supply)	\$10 (30-day supply)
preferred brand	\$20 (30-day supply)	\$20 (30-day supply)
non-preferred brand	50%	50%
compatible with: Health Reimbursement Arrangement (HRA) Health Savings Account (HSA)	HRA	HRA

* CDHP—Consumer Directed Health Plan

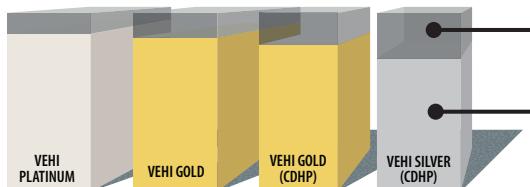
^ stacked—See definition on page 19.

** aggregate—See definition on page 19.

wellness drugs—bluecrossvt.org/vtbluerx

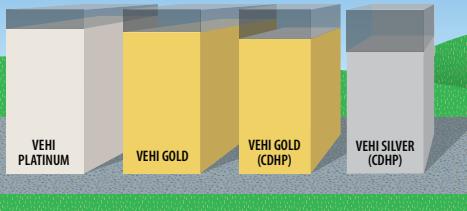


VEHI GOLD CDHP*	VEHI SILVER CDHP*	
Deductible	Deductible	Types of Services
\$1,800 / \$3,600 aggregate** included in medical	\$3,000 / \$6,000 stacked^ included in medical	medical deductible (individual/family) prescription drug deductible
\$2,500 / \$5,000**	\$4,000 / \$8,000^	medical out-of-pocket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



cost-sharing
(co-payments, deductibles and co-insurance)

cost covered by your premium



Compatible with an HRA

General cost-sharing

(applies to most services before your plan provides benefits)

Medical deductible (stacked)

- \$500 per individual
- \$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 per individual
- \$2,600 if you have a two-person, parent and child or family plan

Medical out-of-pocket limit (stacked)

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

Total out-of-pocket exposure (stacked)

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

VEHI Platinum information

Understanding your medical deductible

This plan has a stacked medical deductible.

For individuals, you must meet the \$500 deductible before VEH1 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 VEH1 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 VEH1 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 VEH1 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 VEH1 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 VEH1 will begin to pay 100 percent of the allowed amount for eligible services for that individual.

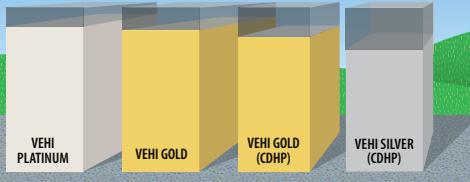
Additionally, any combination of covered family members may meet the family prescription drug out-of-pocket limit of \$2,600 and VEH1 will begin to pay 100 percent of the allowed amount for all family members for the rest of the calendar year.

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.

If you do not select a PCP and reside within the Blue Cross network area, and you enroll in the Platinum or Gold plans, your primary care office visit co-payment will increase to the specialist co-payment.

VEHI Platinum cost-sharing

(NETWORK PROVIDERS ONLY)	YOU PAY	VEHI PAYS
OUTPATIENT CARE		
preventive care (see page 12) 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 (above). After that, VEH 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, VEH 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, VEH 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, VEH 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, VEH 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, VEH 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, VEH 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, VEH pays 100% of the allowed amount for the rest of the year.
medical equipment and supplies prior approval may be required		
routine 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. All cost shares listed are for up to a 30-day supply.	<p>Your cost-sharing:</p> <ul style="list-style-type: none"> ▪ \$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. <p>For individuals, your prescription costs are limited to \$1,300 each year, or \$2,600 each year if you have a family plan.</p>	All but your co-insurance and co-payments at left. VEH 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 most services before your plan provides benefits)

Medical deductible (stacked)

- \$1,200 per individual
- \$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 per individual
- \$2,600 if you have a two-person, parent and child or family plan

Medical out-of-pocket limit (stacked)

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

Total out-of-pocket exposure (stacked)

- \$3,100 per individual
- \$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 VEH1 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 VEH1 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 VEH1 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 VEH1 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 VEH1 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 VEH1 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 VEH1 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.

If you do not select a PCP, and reside within the Blue Cross network area and you enroll in the Platinum or Gold plans, your primary care office visit co-payment will increase to the specialist co-payment.

VEHI Gold cost-sharing

(NETWORK PROVIDERS ONLY)	YOU PAY	VEHI PAYS
OUTPATIENT CARE		
preventive care (see page 12) 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, VEHII 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, VEHII 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, VEHII 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, VEHII 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, VEHII 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, VEHII 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, VEHII 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, VEHII 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	<p>Your cost-sharing:</p> <ul style="list-style-type: none"> ▪ \$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. <p>For individuals, your prescription costs are limited to \$1,300 each year, or \$2,600 each year if you have a family plan.</p>	All but your co-insurance and co-payments at left. VEHII 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 28-29 and page 30-31 for VEHIs CDHP offerings)
- Qualified health care expenses
- Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs).

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

What is a CDHP?

A CDHP is a consumer-directed health plan (sometimes referred to as a consumer-driven health plan). VEHIs 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, VEHIs 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 VEHIs plans—Gold CDHP and Silver CDHP—meet this criteria.

Update to HSA and HRA agreement

As of July 1, 2020, cost-sharing arrangements for public school employees with HRAs and HSAs (except for superintendents) are determined by the statewide health care bargaining process. Access to HRAs and HSAs are also determined by the statewide bargaining process. Please contact your central office for details on the options available to you. (Please note: Private and Independent Schools and Associations are not subject to the terms of statewide bargaining.)

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. 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 Blue Cross 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 VEHIs 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 may be available to school employees who are enrolled in the VEHIs Gold CDHP or the VEHIs 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](https://irs.gov/pub/969).

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:

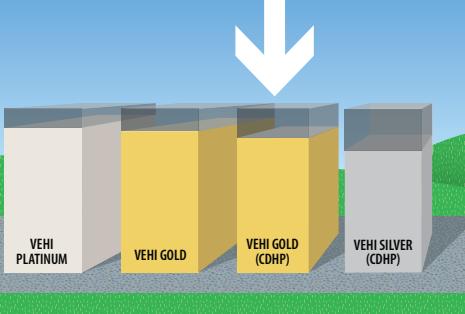
- Cost-sharing you must pay when your health plan provides benefits, such as:
 - Deductibles
 - Co-insurance
 - Co-payments
- Expenses for services that may not be covered by your health plan, such as:
 - Acupuncture
 - Contact lenses
 - Dental treatments
 - Hearing aids
 - Over-the-counter medicines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

Examples of services that are not 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)

- \$1,500 if you have an individual plan
- \$3,000 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.

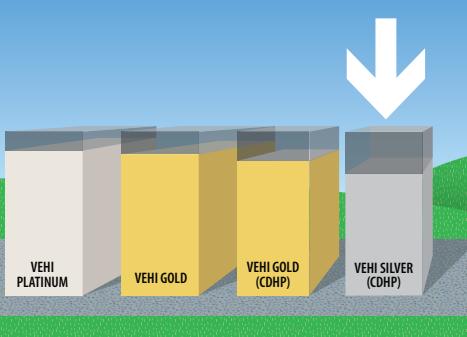
For an individual plan, you must meet the \$1,500 prescription drug out-of-pocket limit before VEHI pays 100 percent of the allowed amount for prescription drugs.

If you're on a two-person, parent and child or family plan, your entire family's combined expenses must meet the \$3,000 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.

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

(NETWORK PROVIDERS ONLY)	YOU PAY	VEHI PAYS
OUTPATIENT CARE		
preventive care (see page 12) 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		
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	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHIC 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, VEHIC pays 100% of the allowed amount for the rest of the year.
diagnostic services include 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, VEHIC 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, VEHIC 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		
home health and hospice care services prior approval required	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHIC 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, VEHIC pays 100% of the allowed amount for the rest of the year.
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, VEHIC 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, VEHIC 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 \$1,500 for a single plan or \$3,000 for other coverage. After that, VEHIC pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit of \$1,500 for a single plan or \$3,000 for other coverage. After that, VEHIC pays 100% of the allowed amount for the rest of the year. This is an aggregate out-of-pocket limit.
wellness drugs Visit bluecrossvt.org/vtbluerx 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. VEHIC 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 per individual
- \$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)

- \$1,500 if you have an individual plan
- \$3,000 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 per individual
- \$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 VEH1 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 VEH1 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 VEH1 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 VEH1

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 \$1,500 prescription drug out-of-pocket limit before VEH1 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 \$3,000 out-of-pocket limit, before VEH1 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.

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

(NETWORK PROVIDERS ONLY)	YOU PAY	VEHI PAYS
OUTPATIENT CARE		
preventive care (see page 12) 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		
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	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEH 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, VEH pays 100% of the allowed amount for the rest of the year.
diagnostic services include 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, VEH 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, VEH 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, VEH 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, VEH 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, VEH 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, VEH pays 100% of the allowed amount for the rest of the year.
medical equipment and supplies prior approval may be required		
routine 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. All cost shares listed are for up to a 30-day supply.	Deductible, then 20% co-insurance until you meet your prescription drug out-of-pocket limit of \$1,500 for a single plan or \$3,000 for family coverage. After that, VEH pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit of \$1,500 for a single plan or \$3,000 for family coverage. After that, VEH pays 100% of the allowed amount for the rest of the year. This is an aggregate out-of-pocket limit.
wellness drugs Visit bluecrossvt.org/vtbluerx 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. VEH covers those drugs at 100% of the allowed amount.	100% of the allowed amount.

INTEGRATED HEALTH

We provide health support and case management services and health support for chronic and rare conditions.

To speak with a licensed nurse or social worker, or to learn more about our case management services, please call (800) 922-8778 or visit our website at bluecrossvt.org/casemanagement.

Case Management

Our caring case management staff ensures you find the right care at the right time for your diagnosis.

Our team has cross-disciplinary medical, mental health and substance use disorder treatment expertise. We look at the physical manifestations of disease, any emotional effects and other possible co-occurring conditions. In a sense, we look at the 'whole you.' Then, we build an individualized plan that helps you navigate the health care system. This means finding the appropriate provider for your needs, coordinating your care between various providers, explaining plan benefits to you and estimating your treatment costs. We'll also connect you to other community-based resources.

Please note, your unique situation may not fall into any of the examples listed in this document. Regardless of your diagnosis, call Blue Cross today to understand how we can help you. Our registered nurses and licensed social workers will create treatment plans and coordinate resources that improve care for each participant. To speak with a registered nurse or licensed social worker or to learn more about our case management services, please call (800) 922-9778 or visit our website at bluecrossvt.org/casemanagement.



Better Beginnings®

Our popular Better Beginnings program helps those who are pregnant create the healthiest, happiest start for their babies. The maternity program offers both pregnancy and postpartum support.

When a pregnant person enrolls in our program, one of our Better Beginnings nurses will work directly with them to identify any risks that could lead to complications while helping to reduce those risks. The program offers a choice of

several different benefit options. We offer an enhanced benefit for those who enroll before the 34th week of pregnancy.

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 our specially selected Better Beginnings book list

Cancer support services

Being diagnosed with cancer is a life-changing event—one that affects you physically as well as emotionally. Our registered nurses and licensed social workers are here to help you and your family during this challenging time.

When you call Blue Cross, you'll speak with a registered nurse or licensed social worker. This person will:

- Be your single point of contact, or dedicated case manager
- Help you understand your health care benefits
- Link you to resources at the American Cancer Society and the Cancer Patient Support Foundation
- Help you make connections with your various providers, including your primary care provider (PCP) and your mental health provider
- Assist you in finding alternative funding and transportation, if necessary and available
- Connect you to cancer-specific resources that are dependent upon your diagnosis

Substance Use Disorder Treatment

Many of us know someone affected by substance use disorder. We feel that we can play an important role by connecting members in need to important resources. If you or a loved one is struggling with addiction, be certain to call our integrated health case management team. We can connect you to the providers, community and care you need to help fight addiction. When you call Blue Cross, you'll:

- Speak with a registered nurse or licensed social worker as your single point of contact
- Get guidance about your substance use disorder treatment benefits—we don't look at just the medical diagnosis, we look at the "whole person" and take into consideration any co-occurring mental health and substance use disorder treatment requirements

- Receive information about local support groups, whether you are in recovery or you have a family member fighting addiction and you need additional support for yourself
- Find out about other local recovery resources

Transgender support services

When you call Blue Cross with questions about gender affirmation services, you'll be connected to a dedicated case manager. This person will:

- Be your single point of contact for as long as you'd like our support
- Help you understand your health care benefits related to transgender services
- Help you make connections with your various providers, including your PCP and your mental health provider
- Connect you to people at Outright Vermont, which provides support and advocacy to young people
- Connect you to people at Pride Center of Vermont, a community center dedicated to supporting lesbian, gay, bisexual, transgender and queer Vermonters
- Give you information about The Trevor Project, a suicide prevention line for trans-teens
- Connect you to Safe Harbor for Trans Teens, an organization for trans youth in need of a temporary home
- Provide information and help you make connections to PFLAG, the nation's largest organization uniting families and allies
- Arrange transgender-specific services

End-of-life support services

When facing the end of your life, it is important to know about available resources and support that can help you understand your options. When you call Blue Cross, you'll:

- Speak with a registered nurse or licensed social worker as your single point of contact
- Get information about the Vermont Ethics Network, which helps Vermont residents, businesses, and hospitals make ethical decisions related to health care
- Learn about the National Hospice and Palliative Care Organization and any associated resources
- Learn about local resources that can help you make decisions that are right for you



Fitness and health events

Blue Cross holds many events each year that help Vermonters get out and get active. Our events 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 our state's most beautiful venues. See the updated calendar at bluecrossvt.org/calendar.

Chronic Condition support

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

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 VEHIC PATH account or access the one you've already set up (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 Integrated Health including Better Beginnings and case management programs

- ✓ Participate in Blue Cross 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



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



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 mindset all year. Join a team for added support or a bit of competition, or activate a cycle to earn PATHpoints in Keeping Fit.



WELLNESS LEADER EVENTS

Wellness events organized by your building leader.

40 points possible



SIZZLIN' SUMMER CHALLENGE

Friends and family fun.

25 points



PATH ADVENTURES

10-week challenge.

50 points possible

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.

Quizzify—These monthly safety and health literacy quizzes provide you the opportunity to brush up on your skills and knowledge for avoiding mishaps. Enjoy the fun facts and smart links out to more info.

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.

Wellness Leader Events—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.

More Courses—Rethinking sugar, mindfulness , emotional wellbeing, and even "Intuitive Eating" are some of the online courses we offer to support your wellbeing.

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



PROGRESS COACHING

Professional coaching for lasting change.

50 points possible



SHOW YOUR SMILE

Have your annual dental check up.

25 points possible

NOTICE OF PRIVACY PRACTICES

How Blue Cross 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 Blue Cross' privacy practices.

In general, Blue Cross' notice of privacy practices explains:

- Blue Cross' 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 Blue Cross' Notice of Privacy Practices is available at bluecrossvt.org/privacy-policy. Or you may request a paper copy by contacting Blue Cross' customer service team at (800) 344-6690.

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 VEHIs wellness programs. VEHIs an inter-municipal insurance association that is approved and overseen by the Vermont Department of Financial Regulation. VEHIs offers non-insured, self-funded health benefit plans, wellness programs and compliance services to schools and other educational organizations in Vermont. The enrollees of VEHIs health benefits plan are active and retired school employees and their dependents. VEHIs health benefit plans are financed by employer and/or employee contributions.

This notice refers to VEHIs 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.

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

NOTICE OF PRIVACY PRACTICES (CONT'D)

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, 2022.

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 BLUE CROSS OR VEH

Always call customer service at Blue Cross 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.



VEHI's health benefit plans are administered by:



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

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.

Phone: (800) 344-6690

Email: customerservice@bcbsvt.com

bluecrossvt.org



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

Blue Cross and Blue Shield of Vermont

Customer Service (800) 344-6690

Case management/ prior approval/
Better Beginnings® (800) 922-8778

VEHI

(802) 223-5040

Vermont-National Education Association (VT-NEA)

(802) 223-6375 Ext. 2420

Vermont School Boards Insurance Trust (VSBIT)

(802) 223-5040

Pharmacy Network

(877) 493-1949

WEBSITES

Blue Cross and Blue Shield of Vermont

bluecrossvt.org

Vermont Education Health Initiative

vehi.org

Pharmacy Network

bluecrossvt.org/vtbluerx