Barre Unified Union Sch - Non Contracted

Benefits Description Wrap Document for
Vermont Education Health Initiative

Effective date: 07/01/26

This version replaces and amends all prior versions.

VEHI's health benefit plans are administered by:

BlueCross BlueShield of Vermont

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

Table of Contents

Your Benefits Materials....4
Eligibility....4
Enrolling in Coverage....4
Paying for Coverage....4
Assistance with Your Questions....4
Open Enrollment....4
Adding Dependents....4
Your Special Enrollment Rights....4
Special Enrollment Provisions....5
COBRA Eligibility....7
Newborns' and Mothers' Health Protection Act....9
Women's Health and Cancer Rights Act of 1998....9
Enrollment Eligibility for Domestic Partners....10

Benefits Description Wrap Document

EMPLOYER: Barre Unified Union School District	**EMPLOYER EIN:** 35-2650739
DESIGNATED GROUP BENEFITS MANAGER: Jennifer Pilarte	**GROUP NUMBER:** 80284
TYPE OF PLAN: Exclusive Provider Organization Plan (PCP)	**SELF-FUNDED PLAN:** The Plan is a non-insured, self-funded health benefits plan. The benefits payable, and other costs of the plan, are financed by contributions made by enrolled employees and/or member employers to the Vermont Education Health Initiative.

☐ If checked, this plan is maintained pursuant to a collective bargaining agreement. You may obtain and examine a copy of this agreement, by contacting your school district.

NAME OF BARGAINING UNIT (IF APPLICABLE, PLEASE NOTE EACH COLLECTIVE BARGAINING UNIT REQUIRES A SEPARATE WRAP DOCUMENT):

OPEN-ENROLLMENT PERIOD: *(For example, October 15—November 15)* Fall of Each Year	**PLAN YEAR:** *(The year during which the plan deductibles, out-of-pocket maximum benefit and certain benefit limitations apply)* Calendar year: January 1—December 31
SECTION 125 YEAR/BENEFIT EFFECTIVE DATE: January 1 ☑ July 1 ☐ Other:	**DOMESTIC PARTNERS:** ☐ If checked, domestic partners are eligible for coverage. Contact your Group Benefits Manager for more information.

ELIGIBILITY: TO BE ELIGIBLE FOR COVERAGE YOU MUST WORK AT LEAST 30_____HOURS PER WEEK.*

*Please note employees must work a minimum of 17.5 hours per week under VEHI rules. There may be additional state or Federal laws limiting employer eligibility requirements.

WAITING PERIOD** *You are eligible for coverage after you complete the following:*

**Please note any waiting period cannot exceed state or Federal law. Generally, VEHI does not allow mid-month changes, except in the case of some special enrollment opportunities. Enrollment takes place on the first of the month. Contact VEHI for more information.

YOUR MONTHLY PREMIUM CONTRIBUTION TO THE COST OF THIS PLAN (based on 1.0 FTE)**:**	
PLATINUM INDIVIDUAL: 378.12 TWO-PERSON: 885.19 PARENT AND CHILD(REN): 765.61 FAMILY: 1132.08	GOLD INDIVIDUAL: 350.35 TWO-PERSON: 829.61 PARENT AND CHILD(REN): 721.11 FAMILY: 1055.92
GOLD CDHP INDIVIDUAL: 264.26 TWO-PERSON: 496.29 PARENT AND CHILD(REN): 408.56 FAMILY: 732	SILVER CDHP INDIVIDUAL: 152.51 TWO-PERSON: 433.98 PARENT AND CHILD(REN): 433.98 FAMILY: 514.04
PLAN ORGANIZER: Vermont Education Health Initiative (VEHI)	**CONTRACT ADMINISTRATOR:** Blue Cross and Blue Shield of Vermont (BCBSVT)
ADDRESS AND CONTACT INFORMATION OF PLAN ORGANIZER: 52 Pike Drive Berlin, Vermont 05602 (802) 223-5040	**ADDRESS AND CONTACT INFORMATION OF CONTRACT ADMINISTRATOR:** 445 Industrial Lane Berlin, Vermont 05602 (800) 247-2583
AGENT AND ADDRESS FOR SERVICE OF LEGAL PROCESS: Jonathan Steiner President 52 Pike Drive Berlin, Vermont 05602	

Eligibility and Enrollment

Your Benefits Materials

Your benefits materials include your:

- Benefit Description
- ID card; and
- Outline of Coverage.

You may receive these documents electronically or on paper. You may request copies at any time without cost to you from your Group Benefits Manager.

Eligibility

You are eligible to participate in this Plan if you are an active full-time or part-time employee working the minimum number of required hours to be eligible for coverage. Your employer, through the Plan Organizer, is responsible for ensuring you are eligible to enroll.

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

- You may add or remove Dependents from your Plan under the conditions noted in this document. To do this, contact your Group Benefits Manager.
- You must cover either all or none of your Dependents who are eligible under your Plan, unless otherwise ordered by a court of law.
- Remember, when you add or remove Dependents, your coverage tier (individual, two-person, parent and child(ren) or family) may change.

Enrolling in Coverage

If you decide to not enroll in coverage when you first become eligible, you or your eligible family members may have to wait until the next Open Enrollment period (explained later) to enroll.

There are also circumstances where you may become eligible under Special Enrollment criteria, or because you experience a change in status, as allowed under your employer's Section 125 plan rules. Please refer to your Group Benefits Manager for more information about a change in status.

If you elect to participate in your employer's health benefit plan, your contribution will be deducted on a pre-tax basis.

If your coverage continues during a period when you are not actively working, such as an unpaid leave of absence or furlough, you must make arrangements with your employer to make your monthly payments.

Paying for Coverage

Your monthly premium contribution is based on the health benefit plan you choose and coverage tier level (individual, two-person, parent child(ren) or family) you elect.

The amount you contribute may change, and changes will be announced prior to your annual Open Enrollment period.

Assistance with Your Questions

If you have questions or comments regarding the Plan's administration, contact your Group Benefits Manager or call BCBSVT's customer service team at the number on the back of your ID card.

Open Enrollment

Your employer has an Open Enrollment period. You may make changes to your existing Plan during the Open Enrollment period.

Your Open Enrollment period, and benefit effective dates, appear on page 1 of this document. Any changes you make during Open Enrollment become effective on the first day of your employer's Section 125 plan year, which is also appears on page 1.

Outside of the Open Enrollment period, you may only make changes if you, or an eligible dependent are entitled to a Special Enrollment, or if you or an eligible dependent experience a change in status under your employer's Section 125 plan. Please note there may be other qualifying events not listed in this document. Please check with your employer's Section 125 plan.

Adding Dependents

You may add or remove Dependents from your Coverage under the conditions noted in this document.

To do this, you must contact your Group Benefits Manager. Remember, when you add or remove Dependents, your coverage tier (individual, two-person, parent and child(ren) or family) may change.

Your Special Enrollment Rights

Federal and state laws give eligible employees and/or their eligible dependents certain Special Enrollment Rights.

These Special Enrollment Rights allow you to change your health benefit plan enrollment during the plan year.

Special Enrollment Rights are available:

- if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons, or
- get married,
- acquire a new dependent by birth, adoption or marriage,
- have any court-ordered dependents, or
- Lose other coverage.

Special Enrollment Provisions

Loss of Coverage

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Marriage, Birth, Adoption, or Placement for Adoption

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents.

You must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Loss of Eligibility under Medicaid or a State Children's Health Insurance Program

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while on Medicaid coverage, or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage.

You must request enrollment within 60 days after you or your dependents' coverage ends under Medicaid or a state children's health insurance program.

Eligibility for Medicaid or a State Children's Health Insurance Program

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. You must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

About Special Enrollment Rights

Permitted Changes

When you are eligible to enroll as a result of a Special Enrollment opportunity, you may enroll in coverage and add new dependents. In addition, if you were already enrolled at the time of the Special Enrollment, you are eligible to change your plan election at that time.

Remember, when you add or remove Dependents, your coverage tier (individual, two-person, parent and child or family) may change your required contribution.

Adding Dependents

Marriage

You must contact your Group Benefits Manager to add a dependent.

- If BCBSVT receives this request within 31 days of the date of marriage, your new type of membership begins the first of the month following the date of marriage.
- If BCBSVT receives your request more than 32 days after the date of your marriage, your new membership begins the first day of the month following BCBSVT's receipt of your request.
- If you fail to add your new Dependents within 60 days, you must wait until an Open Enrollment date to do so.

Birth or Adoption

The Plan automatically 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).

You must contact your Group Benefits Manager to enroll a newborn or adopted Dependent in Plan coverage beyond the initial 60days. (See section about "Special Enrollment Rights").

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

Medical Child Support Orders

If your employer receives an administrative order or court order requiring the Plan to enroll one or more of your dependents, the Plan will provide benefits as required by any qualified medical child support order ("QMCSO").

Your employer has established detailed procedures for determining whether an order qualifies as a QMCSO. Participants' spouses and beneficiaries can obtain, without charge, a copy of these procedures from your Group Benefits Manager.

The effective date of coverage will be three days after BCBSVT receives the administrative order or court order. If the administrative order or court order specifies an alternative effective date, BCBSVT will use the court-ordered date.

Adult Dependent Due to Disability

To continue coverage for an Adult Dependent Due to Disability over age 26, the Dependent's disability must begin before the date the Dependent reaches age 26 and the Dependent must be enrolled for coverage under the Plan before reaching age 26.

You must obtain the necessary forms to apply for coverage. Please contact your Group Benefits Manager to obtain the appropriate forms. BCBSVT must receive the following:

- a subscriber request for coverage for an adult dependent due to disability ; and
- a medical certification for coverage for an adult dependent due to disability, completed by the adult dependent's primary health care provider or attending specialist.

BCBSVT's medical director must review this information and determine the Dependent Incapacitated as defined by law before the Plan will provide coverage.

BCBSVT must receive the information within 31 days of the date the individual would lose coverage to avoid a break in coverage. If BCBSVT receives the above information, more than 31 days after the date the individual loses coverage, he or she would no longer be an eligible Dependent and must wait until the next Open Enrollment period to enroll.

To request a Special Enrollment or to obtain more information about the plan's Special Enrollment provisions, please contact your Group Benefits Manager.

Removing Ineligible Dependents

You must promptly notify your Group Benefits Manager of any change in a dependent's continuing eligibility.

These changes in Dependent eligibility include any of the following events:

- Dependent dies;
- a spouse/party to a marriage or Civil Union divorce or legally separate;
- a domestic partnership separates;
- a Child turns 26; or
- an adult dependent due to disability becomes capable of self-support.
- Dependents become ineligible for coverage at the end of the month after the event occurs.

When Coverage Ends

In general, your Plan coverage will end for you and your Dependents:

- the end of the month in which your employment ends;
- when you stop making required contributions to your Plan;
- when you or your Dependents are no longer eligible to participate in your Plan; or
- when your Plan is terminated.

You may be eligible for benefits after termination of coverage. You may also be able to continue your Plan Coverage under COBRA or Vermont Statute (see"COBRA Eligibility" on page 7 of this document).

Resuming Participation

If you are rehired or if you return from a leave of absence or furlough, you may become eligible to participate in your Plan without satisfying any required employment-waiting period. Make sure your employer is aware of your previous employment when beginning work.

Understanding Continuation of Coverage

Please note the sections below are summaries of the law. Please contact your Group Benefits Manager for full details about continuation of coverage.

COBRA Eligibility

If you face losing health insurance coverage, COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) may apply.

- COBRA doesn't apply if you are fired for gross misconduct.
- COBRA requires your employer to allow you to elect to continue Plan coverage for you and/or your Dependents enrolled for Plan coverage for a certain period of time.
- You must pay for your Coverage.

If you lose coverage, your employer will send you and/or your Dependents a Notice of COBRA Election. If you do not receive this notice, you should contact your Group Benefits Manager right away to avoid any lapse in coverage. You could lose employer-provided coverage under your Plan because you:

- quit your job;
- are laid off;
- enter active military service;
- you are fired (other than for gross misconduct); or
- your job status changes.

In the cases above, your employer must:

- allow you (and your enrolled dependents, if any) to remain on the plan for up to 18 months; and
- must tell you of your COBRA rights when you become eligible.

To continue your Coverage, you must:

- tell your Group Benefits Manager you elect COBRA;
- do so within 60 days after one of the events above (or after your employer tells you of your COBRA rights); and
- then pay the cost of your coverage.
- You may also be charged up to 2 percent of the total cost as a service fee.

If you, or a dependent are disabled or become disabled within 60 days of the COBRA event (see event list above), you can keep coverage longer. You and your covered dependents may continue for up to 29 months. There may be a service fee. Please contact your Group Benefits Manager for details.

In other cases where your Dependents lose eligibility for plan coverage (such as divorce, a Dependent reaching the maximum age of 26 or your death), your Dependents may elect to continue coverage for up to 36 months. Please check with your Group Benefits Manager or an attorney for more information.

Note: You may have other options available to you when you lose group health coverage. Continuation with your group coverage may not be your best option. You may be eligible to buy an individual plan through Vermont Health Connect. By enrolling in coverage through Vermont Health Connect, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. If you choose to continue your group coverage, you may be ineligible to enroll in an individual plan through Vermont Health Connect until a new open enrollment or special enrollment period.

Continuation rights do not apply if:

- you are covered by Medicare;
- the covered employee (participant) was not covered on the date of the qualifying event;
- you are newly eligible for coverage in a group in which you were not covered before the qualifying event,
- and no preexisting condition exclusion applies; or
- you have lost your job due to misconduct as defined by law.

Continuation of insurance ends when:

- 18 months pass from the date you would have lost coverage;
- you fail to make a timely payment of the required contribution;
- you become eligible for Medicare or another group plan; or
- your employer stops offering any group plan (if your group replaces this coverage with a similar plan, you may continue coverage under that plan).

Remember you are required to maintain minimum essential coverage beginning January 1, 2014 to avoid paying a government fee or penalty for any months you are without that coverage.

Conversion Rights

When your COBRA eligibility ends, you may be eligible for non-group coverage, Medicaid or Medicare coverage. If you are eligible, you will have the opportunity to enroll in a product offered through Vermont Health

Connect or directly though Blue Cross and Blue Shield of Vermont without a break in coverage. To do this, your coverage must be effective within 30 days after your COBRA enrollment terminates.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, eligible employees are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted due to military service, plus additional seniority, rights and benefits that the employee would have attained if he or she had not left employment.

You may continue your health benefit plan for a period of time by paying premiums as stated per your employer's policy or your collectively bargained agreement.

If you choose not to continue your medical coverage while on military leave, you may reinstate coverage with no waiting periods or exclusions (exception the exclusion that applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled work day following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days;
- Return to or reapply for reemployment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days; or
- Return to or reapply for reemployment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

Continuation of Coverage While on a Family and Medical Leave

Under the Family and Medical Leave Act (FMLA), eligible employees may generally take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected medical coverage benefits during this time. If you take this unpaid leave and wish to continue your medical coverage under the Plan, you may be billed directly on a monthly basis, at the same amount applicable before the unpaid leave began.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care;
- To care for a Spouse, child, or parent who has a serious health condition; or
- For your own serious health condition.

The number of weeks of unpaid leave available to you for family and medical reasons may vary based on the applicable state law requirements.

Rescission of Coverage for Failure to Provide Accurate and Current Information

Coverage under the Plan may be retroactively canceled or terminated (Rescinded) if a Covered individual acts fraudulently or intentionally makes material misrepresentations of fact. It is your responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also your responsibility to update previously provided information and statements. Failure to do so may result in individuals being canceled, and such cancellation may be retroactive.

A determination by the Plan that a Rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Covered individual whose coverage is being Rescinded will be provided a 30-day notice period as required under Health Care Reform and regulatory guidance. Claims incurred after the retroactive date of termination will not be processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as incorrectly paid Claims under this Plan and the benefits paid are subject to recovery by the Plan.

Other important plan information

Newborns' and Mothers' Health Protection Act

Federal law requires that health plans must offer coverage for at least 48 hours of inpatient hospital care following normal vaginal deliveries, and for at least 96 hours of care following caesarean deliveries. The time periods begin from the time of delivery or the time of hospital admission, if the delivery occurs outside of the hospital.

BCBSVT does not have standard day-limit restrictions on the length of maternity stays. Instead, BCBSVT reviews each admission for medical necessity. In any event, BCBSVT does not limit hospital stays to less than the durations required by the law. As always, if you have questions about your maternity benefits please call BCBSVT's customer service team at the number on the back of your ID card.

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and co-insurance amounts that are consistent with those that apply to other benefits under the plan.

If you have questions about these benefits, please call BCBSVT's customer service team at the number on the back of your ID card.

Information about Domestic Partner Coverage

Please see page 1 of this document to verify if your employer covers domestic partnerships.
If your employer covers domestic partners the following provisions apply:

Enrollment Eligibility for Domestic Partners

Domestic Partners (and their Dependents) are eligible to enroll during:

- the initial enrollment period; or
- Open Enrollment

To enroll an eligible Domestic Partner, you (employee) and the Domestic Partner must:

- complete and sign a Statement of Domestic Partnership. You may obtain these forms from your Group Benefits Manger.
- find a notary public to witness the signature of this document.
- provide the following documentation in support of the Statement of Domestic Partnership:
  - proof of common residence; and
  - proof of financial interdependence, e.g., joint bank accounts or credit cards, executed powers of attorney, listing of your Domestic Partner as a beneficiary on your insurance policy and/or designated signatures on safety deposit boxes.

Effective Date of Coverage for Domestic Partners

The effective date of coverage of an eligible Domestic Partner and any initially eligible Dependents of the Domestic Partner will be as follows:

- When this Plan replaces a prior carrier, if the prior carrier already had Domestic Partnership coverage and a partner qualified for coverage under the prior plan's Domestic Partnership policy, coverage may begin on this Plan's effective date.
- If the Plan Covers Domestic Partnership for the first time, and a partner qualifies for coverage under the new Domestic Partnership policy, coverage may begin on the Plan's effective date if BCBSVT receives a Statement of Domestic Partnership.
- When an existing Plan obtains Domestic Partnership coverage for the first time, an eligible Domestic Partner's coverage may begin the first of the month after BCBSVT receives a Statement of Domestic Partnership and an application. BCBSVT must receive this request within 30 days of when the Plan begins coverage for Domestic Partners.
- When an employee is first hired, an eligible Domestic Partner's coverage may begin on the employee's effective date if BCBSVT receives a Statement of Domestic Partnership with the employee's application.

In all other cases, an eligible Domestic Partner's coverage may begin:

- on an Open Enrollment date if BCBSVT receives a Statement of Domestic Partnership and an application form before the Open Enrollment date; or
- the first of the month following the Open Enrollment date, if the Plan receives the Statement of Domestic Partnership and application during the month in which the Open Enrollment date occurs.

Termination of Domestic Partnership

When two parties no longer meet requirements for Domestic Partnership status, the Participant must complete and file a Termination of Domestic Partnership form within 30 days of the change in status. Forms are available from your Group Benefits Manager.

The Participant must mail a copy of the termination notice to the Domestic Partner within 14 days of completing the notice. Termination will be effective on the first day of the month following BCBSVT's receipt of the notice.

If a Participant cancels coverage for a Domestic Partner, he or she may not include another Domestic Partner on the Plan until nine months from the date of cancellation.

Vermont Statue—Continuation of Coverage for Domestic Partners

Domestic Partners and their Dependents do not meet the definition of qualified beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA); however, the Vermont Statute for Continuation of Coverage may apply. Check with your Group Benefits Manager to see if you are eligible for Vermont continuation coverage.

Please note the sections below are summaries of the law/statute. Please contact your Group Benefits Manager for full details about continuation coverage.

Vermont law requires your employer to keep you on your Plan after a civil union dissolution, or legal separation resulting in a loss of coverage for a covered employee's spouse, civil union partner or domestic partner if domestic partners are covered under your employer's plan.

Generally, Vermont continuation of coverage lasts for 18 months. Continuation of coverage could end sooner, under the following circumstances:

- You don't pay your premiums on a timely basis
- Your employer ceases to maintain any group health insurance plan

- You obtain coverage with another employer's group health insurance plan that does not contain any exclusion or limitation for pre-existing conditions
- You become entitled to Medicare benefits.

NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex.

BCBSVT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

BCBSVT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394
TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of
Health and Human Services
Office for Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

For free language-assistance services, call (800) 247-2583.

ARABIC

للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583.

CHINESE

如需免費語言協助服務，請致電(800) 247-2583。

CUSHITE (OROMO)

Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.

FRENCH

Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

GERMAN

Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

ITALIAN

Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

JAPANESE

無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI

निःशुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN

Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)

Za besplatnu uslugu prevođenja, pozovite na broj (800) 247-2583.

SPANISH

Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

TAGALOG

Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE

Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.

VEHI's health benefit plans are administered by:

BlueCross BlueShield of Vermont

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

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www.bcbsvt.com

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(1/1/2018)