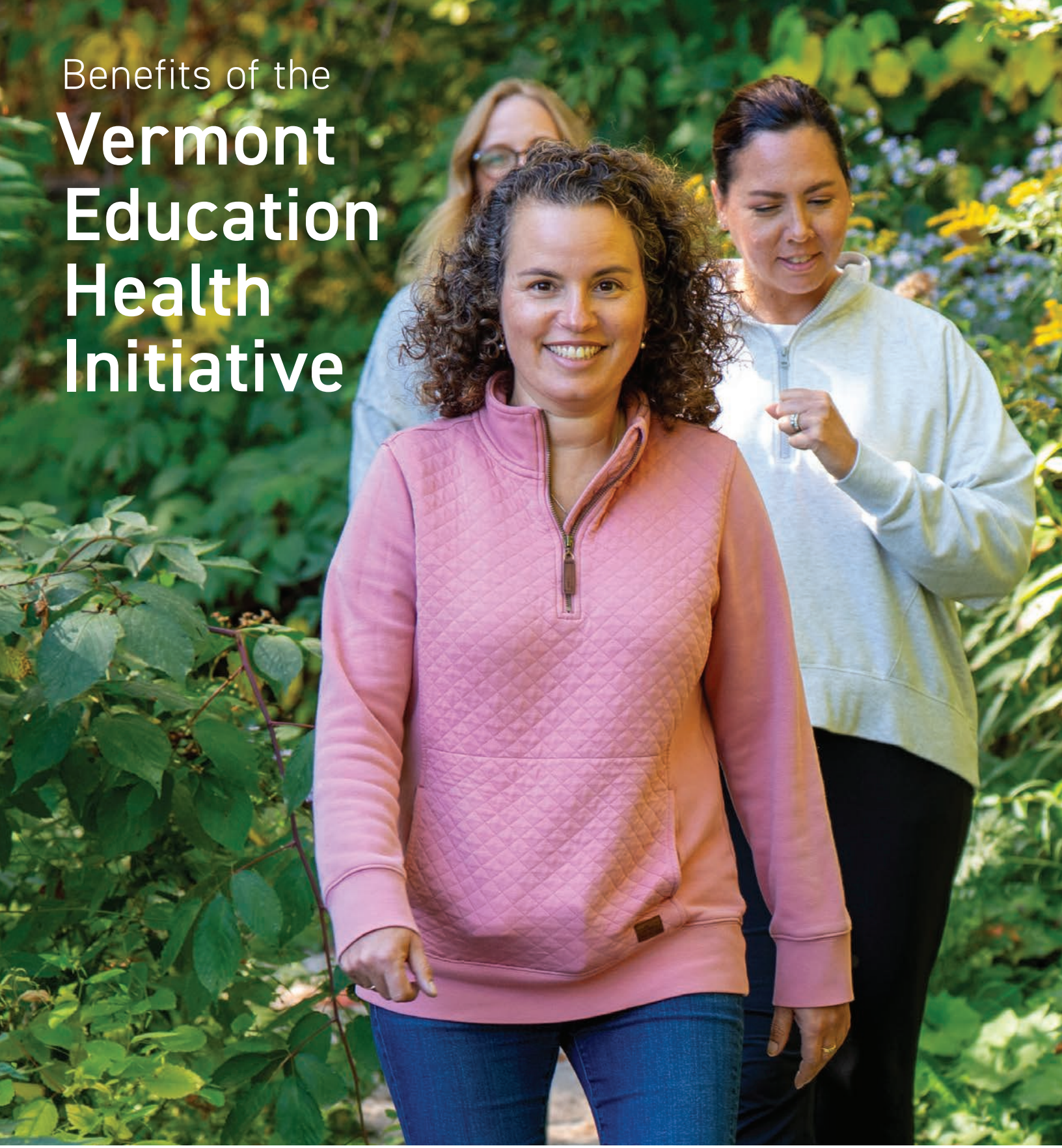
Benefits of the

Vermont Education Health Initiative



VEHI's health benefit plans are administered by:

BlueCross BlueShield of Vermont

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

vehi

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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 three decades. It is managed jointly by the Vermont School Boards Insurance Trust (VSBIT) and the Vermont-National Education Association (VT-NEA).

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

Blue Cross VT 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 healthcare market, healthcare reform initiatives, and regulatory compliance under federal and state law.

We urge you to consider yourself a purchaser of healthcare, 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 healthcare 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 healthcare 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.

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

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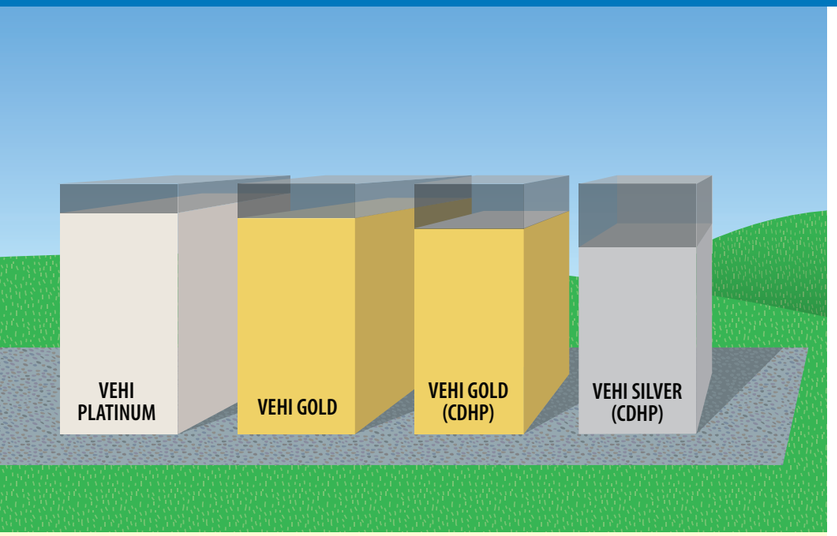


VEHI's four health plans:

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

CDHP: Consumer Directed Health Plan

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:

- 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 22-25.)
- CDHPs offer a wellness drug benefit, which provides coverage for certain drugs that can help you maintain your health, with no cost to you
- Comprehensive medical coverage in every major benefit category
- A range of cost-sharing options (see the comparison on page 20-21)

For all plans, an eligible primary care provider (PCP) must be provided for all employees and their dependents, except if the member resides outside of Vermont. You don't need referrals to see in-network specialists.

CDHP: Consumer Directed Health Plan

- 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.
- The freedom to choose providers from the nationwide EPO/PPO Network without a referral
- The security of the Blue Cross VT ID card—the most recognized symbol in health benefits worldwide
- Access to a local award-winning, Blue Cross and Blue Shield of Vermont customer service team available Monday – Friday, 7 a.m. – 6 p.m., and 24-hour, seven-day-a-week access via Blue Cross VT's website **bluecrossvt.org**
- State-of-the-art wellness programming offered by VEHI PATH and Blue Cross VT, 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
- 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; and
  - behavioral health services.
- One routine vision exam per member, per calendar year for a $20 copayment.

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, the period that falls between October and November) 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 VT receives your request before this date, they will make the change effective on the open enrollment date.

Open Enrollment 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 VT must receive your marriage notification within 60 days following your marriage. If Blue Cross VT 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 VT 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 VT receives your request.

If you fail to add your new dependents within 60 days, you must wait until your next open enrollment date or another qualifying event..

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 VT must receive your request for adding a dependent child to continue benefits for the child past 60 days. If Blue Cross VT 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 you 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 VT or when Blue Cross VT receives the court order, whichever is sooner. If the court order specifies a different effective date, Blue Cross VT will use that date. Blue Cross VT 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 VT'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 VT Customer Service at (800) 344-6690 as soon as possible.

FIND CARE NEAR YOU

Find a Doctor Near You

1. Visit **bluecrossvt.org/find-doctor**
2. Select **Find a Doctor Near You**
3. Get started by entering your Blue Cross VT ID card (First 3 characters VEI) or dismiss, and choose your network and location.
   - To search in-network options within Vermont and contiguous counties, select BCBSVT Network
   - To search in-network options within in Vermont or nationally, select the appropriate option from the Network field based on your plan.
4. You can then search by provider name, location, or specialities.
5. Once results are populated, you can refine your search using the Filters function. Filters include distance, languages, medical specialty, and more.

You can also use the Map View option to view the results on a map.

Up to 4 providers can be compared by selecting the Compare box on each result listing.

Find And Estimate Costs For Procedures And Services

The cost transparency tool, available to members in our Member Resource Center (MRC), allows you to better understand costs of upcoming services and procedures, as well as search more cost-effective options.

1. Log in or register for the MRC at **bluecrossvt.org/MRC**
2. Under the "My Providers" menu, choose the Estimate Costs option.
3. Follow the steps within the cost tool to find estimates for services and procedures.

Finding an Eye Doctor

To find a VSP Vision Care network provider, call VSP's customer service team at **(800) 877-7195**. You can also:

1. Visit **bluecrossvt.org/find-doctor**
2. Select **Find a VSP Eye Doctor**
3. You can search location, office or doctor.

Locate a Vermont Blue Rx℠ Pharmacy

To find a network pharmacy:

1. Visit **bluecrossvt.org/vermontbluerx**
2. Select **Find a Pharmacy**
3. Select Vermont Blue Rx from the "Plan Options" dropdown
4. Search by pharmacy name or location

If you have questions, call our customer service team at the number on the back of your Blue Cross VT ID card or our national provider finder line at **(800) 810-BLUE (2583)**.

For pharmacy network questions call Vermont Blue Rx at **(877) 493-1949**.

Understanding your networks	
PCP required	An eligible primary care provider (PCP) must be provided for all employees and their dependents, except if the member resides outside of Vermont. You don't need referrals to see in-network specialists.
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 VT 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 VT's customer service team at (800) 344-6690.
Finding a Local Vermont provider	To find a Blue Cross VT provider visit **bluecrossvt.org/find-doctor** or call Blue Cross VT'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).

EMERGENCY AND URGENT CARE

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

There may be times when you cannot see your PCP, whether it's after regularly scheduled hours, or in the event your PCP cannot see you as soon as is necessary. Using an urgent care facility, when appropriate, can help you save lengthy hours spent waiting in the emergency room for care and lower your healthcare 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 VT's customer service team at (800) 344-6690.

	VEHI Platinum	VEHI Gold	VEHI Gold CDHP	VEHI Silver CDHP
Urgent care	$75	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Emergency room	$250	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance

What is an urgent medical condition?

Any health issue that requires prompt attention (typically within 24 hours) but is not immediately life-threatening. Examples include: high fever, deep cuts or wounds, flu or cold*, sprains, sore throat*, abdominal pain*, eye injuries, or infections.

*Telemedicine may also be an option.

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 VT 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?

- While a trip to the doctor's office often costs less than the emergency room, sometimes you can't avoid the hospital. Call 911 or head to the emergency room immediately if you're facing a potentially life-threatening situation.
- Medical emergencies such as a heart attack or stroke symptoms, chest pain, difficulty breathing, choking, severe burns, seizures, head/neck injuries, or compound factures warrant emergency room treatment.

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.

A faster, easier way to see a provider. Advice from a provider is as close as your computer, tablet, or smart phone. All plans include 24/7 telemedicine access. This means you can access the care you need anywhere at anytime. For more information, visit **bluecrossvt.org/telemedicine**.

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.

What is telemedicine?

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

- Nutritional Counseling
- Behavioral Health Services
- Respiratory Infections
- Bronchitis
- Urinary Tract Infections
- Sore Throat
- Rashes
- Pink Eye
- Cough
- Flu
- Stuffy Nose
- Allergies

When should I use telemedicine?

Our telemedicine providers can also prescribe medication. *(Please note distribution of prescriptions are subject to state law).* 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 children and cannot leave the house

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

What is Hinge Health?

Is Hinge Health for me?

Whether a new injury or ongoing aches, Hinge Health is for anyone living with joint or muscle pain.

What does my program include?

- Unlimited access to your personalized exercises and stretches developed by physical therapists
- Convenient exercise sessions you can do anytime, anywhere with the Hinge Health app
- Dedicated 1-on-1 support from a physical therapist and qualified health coach

Who is in my care team?

Your care team includes a physical therapist and qualified health coach. You can connect with them via text, email, phone call, or video chat to ask questions, set goals, and more.

How much does the program cost?

Hinge Health is available to eligible employees at no additional cost.

Who is eligible?

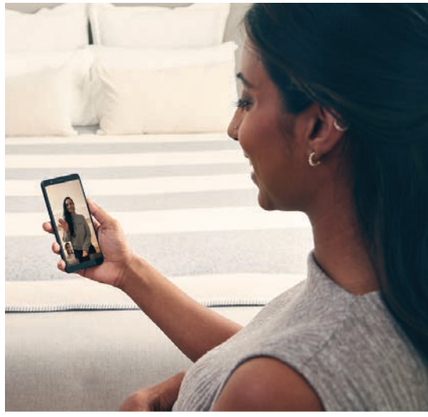
Subscribers and dependents 18+ enrolled in a Blue Cross VT medical plan through Vermont Education Health Initiative (VEHI) are eligible.

We provide members with personalized, expert-developed exercise therapy plans for lasting pain relief.

To learn more and apply, scan the QR code or visit **hinge.health/vehi**.

Questions? Call (855) 902-2777

DISCLAIMER: Vermont Health Education Initiative (VEHI) provides the Hinge Health program through a direct contract with Hinge Health. Hinge Health is separate from your health plan.



What is preventive care?

The term "preventive care" refers to healthcare 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, coinsurance, or copayments). 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 healthcare 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 coinsurance, or copayments.

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 healthcare 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 healthcare provider about additional preventive care. You may have cost-sharing if you have such services.

Maternity Health with Better Beginnings®

Expecting mothers are encouraged to enroll in Blue Cross VT's free program before they are 34 weeks pregnant. See page 33 for details or call **(800) 922-8778**.

Understanding your prenatal coverage

Your plan covers OB-GYN office visits and childbirth and delivery services. Due to recent coding guidance changes, providers will no longer be waiting until after the delivery of your baby to submit claims. Claims for all office visits, lab services, testing, labor management, and delivery will be submitted as they occur. Laboratory services and tests are subject to deductible and coinsurance, including hospital-related labor management, and delivery charges.

You won't pay copayments, deductible, and coinsurance for preventive maternity care defined under the Affordable Care Act. (See below for details regarding no-cost preventive care during and after pregnancy.)

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.

Maternity Health with Better Beginnings®

Expecting mothers are encouraged to enroll in Blue Cross VT free program before they are 34 weeks pregnant. See page 33 for details or learn more at bluecrossvt.org/betterbeginnings or call (800) 922-8778

Preventive care during and after pregnancy

For full details, please see the preventive care guide for you and your family available at **bluecrossvt.org/documents/preventive-care-guide**. Federal and state regulators recommend certain screenings for pregnant members.

The Blue Cross VT 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.

As a VEHI member, you will receive your prescription drugs through Blue Cross VT's network of pharmacies. Present your Blue Cross VT ID card at a network pharmacy and the pharmacist will file a claim for you. Most major chains (Kinney, Walgreens, CVS, etc.) and a large percentage of pharmacies nationwide currently belong to this network. Visit ***bluecrossvt.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, **bluecrossvt.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.

VEHI also does not provide coverage for prescription drugs containing Glucagon-Like Peptide-agonist (GLP-1) products prescribed for conditions other than diabetes (including but not limited to Wegovy, Zepbound, and Saxenda). *Note:* Wegovy is not excluded if you are an adult with obesity and established cardiovascular disease defined as a prior heart attack, stroke, or symptomatic peripheral arterial disease and your Provider prescribes Wegovy to reduce the risk of major adverse cardiovascular events. Prior approval is required.

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 coinsurance 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 **bluecrossvt.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 visting 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.

Log into to the **Member Resource Center** at **bluecrossvt.org/member-logins** to manage your prescriptions and sign up for the home delivery program.

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

Prior approval

Blue Cross VT's prior approval list changes periodically. The most current list is found online or by calling Vermont Blue Rx. 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 VT may ask for documentation.

Step therapy

Blue Cross VT'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.

Medication guidance

Blue Cross VT offers one-on-one consultations 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 VT to schedule your free confidential consultation: **(802) 371-3462**.

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 coinsurance 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 page 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%	Covered at 100%	Covered at 100%	Covered at 100%
Diabetic **testing supplies** obtained through the **pharmacy**	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Diabetic **medical equipment** and **pump supplies** obtained through a **durable medical equipment supplier**	Covered at 100%	Covered at 100%	Deductible, then coinsurance	Deductible, then coinsurance

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 VT customer service (800) 344-6690 to discuss coverage and benefits.

Understanding the prior approval process

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

Prior approval is needed for out-of-network care and for certain services and drugs 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 VT 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 VT customer service at (800) 344-6690.

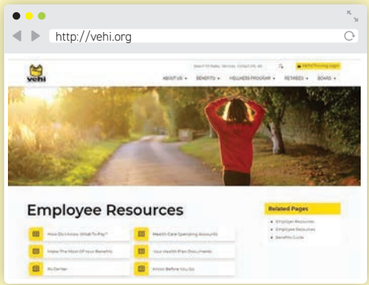
General policy exclusions

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

DIGITAL RESOURCES & COST TRANSPARENCY



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.

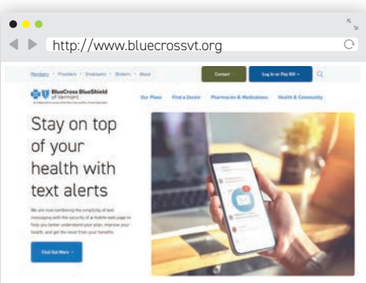
For more information about VEHI's wellness program, PATH, please see page 34.

Blue Cross VT's secure member resource center

From Blue Cross VT's 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 email 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.



- Have your member identification card on hand to complete your registration
- You must enter your information in a specific format. Review the graphic on the website for help or call customer service.

How much might you pay out of pocket for your healthcare?

Our cost estimate tool helps you check and compare your estimated out-of-pocket costs for many types of care from different providers and facilities, including:

- Office visits with your primary care physician or specialist
- Diagnostic imaging, like X-rays, CT scans, or MRIs
- Procedures, like a colonoscopy or knee replacement

How to Use the Cost Estimate Tool

1. Log in to the Member Resource Center (MRC).

   Don't have an account? Sign up using your member ID card.
2. Navigate to the "My Providers" menu.
3. Choose "Estimate Costs," then click "Accept" at the bottom of the page.
4. Click the tile that says "Procedure Costs" to browse for common terms or search for a procedure by name.
5. Select a service or procedure to see in-network providers and facilities in your area, along with the total estimated cost for each.
6. Choose a provider or facility to see a more detailed breakdown, including how much your Blue Cross VT health plan will pay and your estimated share of the cost through coinsurance, copayment, or your plan's deductible.

Please note, these are only estimates. Actual costs may vary depending on several factors, including how the provider bills us for the procedure. This estimate also does not include any Health Spending Account funding that may be available to you through your employer.

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 copayments, deductibles and coinsurance 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 copayment?

A copayment is a fixed dollar amount you must pay for applicable, covered services. Copayments apply to your out-of-pocket limit.

What is coinsurance?

Coinsurance is a percentage of the allowed amount you must pay. For example, you will continue to pay coinsurance until you meet your medical out-of-pocket limit. For prescription drugs (depending upon what plan you choose), you may pay coinsurance for certain drugs until you meet your Prescription Drug out-of-pocket limit.

What is the allowed amount?

The allowed amount is the amount VEHI pays a contracted, network provider for a covered service. This amount is set based on competitive information, plan experience, provider feedback, employer group feedback, and government reimbursement levels. 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 VEHI plan has a stacked deductible, and you are on a two-person, parent and child or family plan, a covered family member may meet the individual deductible and begin receiving post-deductible benefits. When your family's expenses reach the family deductible, all family members receive post-deductible benefits, **which may include copayments or coinsurance**.

What is an aggregate deductible?

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

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

What is a stacked out-of-pocket limit?

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

What is an aggregate out-of-pocket limit?

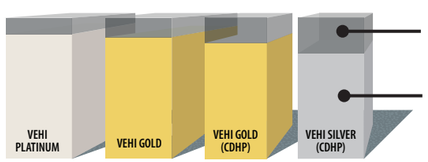
If your VEHI plan has an aggregate out-of-pocket limit and you're on a two-person, parent and child or family plan, you do not have an individual out-of-pocket limit.

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

VEHI PLAN COMPARISON

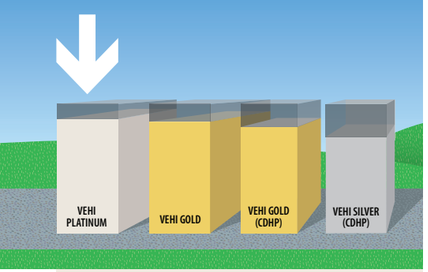
Types of Services	VEHI PLATINUM Deductible	VEHI GOLD Deductible	VEHI GOLD CDHP* Deductible	VEHI SILVER CDHP* Deductible	Types of Services
medical deductible (individual/family)	$500 / $1,000 | stacked^	$1,200 / $2,400 | stacked^	$1,800 / $3,600 | aggregate**	$3,500/$7,000 | stacked^	medical deductible (individual/family)
prescription drug deductible	$0	$0	included in medical	included in medical	prescription drug deductible
medical out-of-pocket limit (individual/family)	$1,500 / $3,000^	$1,800 / $3,600^	$2,500 / $5,000**	$4,000 / $8,000^	medical out-of-pocket limit (individual/family)
prescription drug out-of-pocket limit (individual/family)	$1,300 / $2,600^	$1,300 / $2,600^	$1,750/$3,500**	$1,750/$3,500**	prescription drug out-of-pocket limit (individual/family)
TOTAL out-of-pocket exposure for both medical and prescription drug benefits (individual/family)	$2,800 / $5,600	$3,100 / $6,200	$2,500 / $5,000	$4,000 / $8,000	TOTAL out-of-pocket exposure for both medical and prescription drug benefits (individual/family)
Service Categories	**Copayment/Coinsurance**	**Copayment/Coinsurance**	**Copayment/Coinsurance**	**Copayment/Coinsurance**	**Service Categories**
preventive care	$0	$0	$0	$0	preventive care
primary care office visit	$25	$25	deductible, then 20% coinsurance	deductible, then 20% coinsurance	primary care office visit
mental health/substance abuse office visit	$25	$25	deductible, then 20% coinsurance	deductible, then 20% coinsurance	mental health/substance abuse office visit
specialist office visit	$35	$35	deductible, then 20% coinsurance	deductible, then 20% coinsurance	specialist office visit
urgent care	$75	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	urgent care
emergency room	$250	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	emergency room
ambulance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	ambulance
durable medical equipment (DME)	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	durable medical equipment
radiology (MRI, CT, PET)	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	radiology (MRI, CT, PET)
outpatient care	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	outpatient care, general hospital
inpatient care, general hospital	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	inpatient care
routine vision exam with a VSP provider	$20	$20	$20	$20	vision exam
Service Categories	**Copayment/Coinsurance**	**Copayment/Coinsurance**	**Coinsurance**	**Coinsurance**	**Service Categories**
wellness drugs #	n/a	n/a	0%	0%	wellness drugs #
generic tier 1	$4 *(30-day supply)*	$4 *(30-day supply)*	deductible, then 20% coinsurance	deductible, then 20% coinsurance	generic tier 1
generic tier 2	$10 *(30-day supply)*	$10 *(30-day supply)*	deductible, then 20% coinsurance	deductible, then 20% coinsurance	generic tier 2
preferred brand	$20 *(30-day supply)*	$20 *(30-day supply)*	deductible, then 20% coinsurance	deductible, then 20% coinsurance	preferred brand
non-preferred brand	50%	50%	deductible, then 20% c-insurance	deductible, then 20% coinsurance	non-preferred brand
compatible with: Health Reimbursement Arrangement (HRA) Health Savings Account (HSA)	HRA	HRA	HRA, HSA	HRA, HSA	compatible with: Health Reimbursement Arrangement (HRA) Health Savings Account (HSA)

* CDHP–Consumer Directed Health Plan
^ stacked–See definition on page 19.
** aggregate–See definition on page 19.
# wellness drugs–**bluecrossvt.org/vtbluerx**



cost-sharing
(copayments, deductibles and coinsurance)

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 VEHI begins paying for applicable medical services.

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

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

Understanding your medical out-of-pocket limit

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

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

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

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

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

Understanding your prescription drug out-of-pocket limit

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

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

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

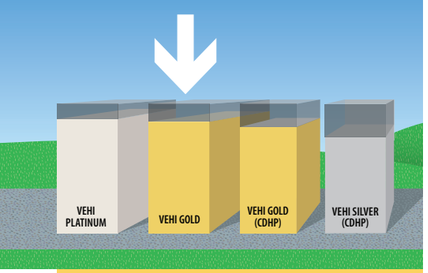
Additionally, any combination of covered family members may meet the family prescription drug out-of-pocket limit of $2,600 and VEHI will begin to pay 100 percent, of the allowed amount,for all family members for the rest of the calendar year.

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

If you do not select a PCP and reside within the Blue Cross VT 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 copayment	All but your copayment
mental health and substance abuse office visits	$25 copayment	All but your copayment
specialist office visits may require prior approval	$35 copayment	All but your copayment
maternity office visits	One $25 copayment for all prenatal and post-partum care from one provider	All but your copayment
chiropractic care prior approval required after 12 visits per year	$35 copayment	All but your copayment
diagnostic services includes labs, X-ray, etc.; may require prior approval	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100%.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
outpatient surgery prior approval may be required		
outpatient physical, occupational, and speech therapy up to 30 visits combined per calendar year		
urgent care at an urgent care facility	$75 copayment	All but your copayment
emergency care	$250 copayment (waived if admitted)	All but your copayment
INPATIENT CARE		
inpatient care, general hospital Includes maternity, newborn care, mental health, and substance abuse.	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
HOME CARE AND REHABILITATION SERVICES		
inpatient skilled nursing or rehabilitation prior approval required for rehabilitation	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
home health and hospice care services prior approval required		
private duty nursing up to 14 hours per member per calendar year		
OTHER SERVICES		
ambulance prior approval required for non-emergency transport	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
medical equipment and supplies prior approval may be required		
routine vision exam one exam per year	$20 per exam	All but your copayment
PRESCRIPTION DRUGS		
prescription drugs (including home delivery) Prior approval may be required. All cost shares listed are for up to a 30-day supply.	Your cost-sharing: ▪ $4 copayment for generics on Tier 1 (lower-cost generics) ▪ $10 copayment for generics on Tier 2 (higher-cost generics) ▪ $20 copayment for preferred brand-name drugs ▪ 50% coinsurance for non-preferred brand-name drugs. For individuals, your prescription costs are limited to $1,300 each year, or $2,600 each year if you have a family plan.	All but your coinsurance and copayments at left. VEHI pays 100% of the allowed amount if you meet your prescription drug out-of-pocket limit of $1,300 for a single plan or $2,600 for a two-person, parent/child or family plan. This is a stacked out-of-pocket limit.



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

VEHI Gold information

Understanding your medical deductible

This plan has a stacked medical deductible.

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

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

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

Understanding your medical out-of-pocket limit

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

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

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

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

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

Understanding your prescription drug out-of-pocket limit

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

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

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

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

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

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

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 copayment	All but your copayment
mental health and substance abuse office visits	$25 copayment	All but your copayment
specialist office visits may require prior approval	$35 copayment	All but your copayment
maternity office visits	One $25 copayment for all prenatal and post-partum care from one provider	All but your copayment
chiropractic care prior approval required after 12 visits per year	$35 copayment	All but your copayment
diagnostic services includes labs, X-ray, etc.; may require prior approval	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
outpatient surgery prior approval may be required		
outpatient physical, occupational, and speech therapy up to 30 visits combined per calendar year		
urgent care		
emergency care		
INPATIENT CARE		
inpatient care, general hospital Includes maternity, newborn care, mental health, and substance abuse.	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
HOME CARE AND REHABILITATION SERVICES		
inpatient skilled nursing or rehabilitation prior approval required for rehabilitation	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
home health and hospice care services prior approval required		
private duty nursing up to 14 hours per member per calendar year		
OTHER SERVICES		
ambulance prior approval required for non-emergency transport	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
medical equipment and supplies prior approval may be required		
vision exam one exam per year	$20 per exam	All but your copayment
PRESCRIPTION DRUGS		
prescription drugs (including home delivery) Prior approval may be required. All cost shares listed are for up to a 30-day supply.	Your cost-sharing: ▪ $4 copayment for generics on Tier 1 (lower-cost generics) ▪ $10 copayment for generics on Tier 2 (higher-cost generics) ▪ $20 copayment for preferred brand-name drugs ▪ 50% coinsurance for non-preferred brand-name drugs. For individuals, your prescription costs are limited to $1,300 each year, or $2,600 each year if you have a family plan.	All but your coinsurance and copayments at left. VEHI pays 100% of the allowed amount if you meet your prescription drug out-of-pocket limit of $1,300 for a single plan or $2,600 for a two-person or family plan. This is a stacked out-of-pocket limit.

STATEWIDE NEGOTIATIONS FOR PUBLIC SCHOOL EMPLOYEES

Out-of-pocket costs, premium cost-sharing terms, and benefit eligibility standards for **active public-school employees** are governed by the terms and conditions of statewide negotiations (hereafter, "statewide agreement") conducted by the Commission of Public-School Employee Health Benefits. The terms of the current statewide agreement are in effect from January 2023 through December of 2028.

Employees of private or independent schools and school-related associations are not subject by statute to the terms of statewide negotiations. These employees should contact their human resource department to learn about the costs and eligibility conditions of their healthcare benefits.

Public-school employees who are subject under Vermont Statute to the terms and conditions of statewide negotiations include:

a. **Licensed teachers:** Employees of Vermont school districts and supervisory unions providing employment services that require a professional teacher's license from the Vermont Agency of Education;

b. **Licensed administrators (except for superintendents):** Employees of Vermont school districts and supervisory unions providing employment services that require a professional administrator's license from the Vermont Agency of Education; and

c. **Non-licensed support staff:** Employees of Vermont school districts and supervisory unions defined as "municipal employees" in 21 V.S.A. Section 1722 and who provide employment services that do not require a license from the Vermont Agency of Education.

VEHI members can learn more about the specific terms of statewide negotiations, per their work classifications, and about health spending accounts (HRAs, HSAs and FSAs) on the VEHI website at the following address: **vehi.org/vehi-health-benefit-options/** or by contacting their human resources department or local union representative.

HEALTH SPENDING ACCOUNTS

This section is written specific to the statewide agreement for public schools and may be contrary to what is allowed or covered by other independent schools, school-related associations, or other employers.

Health Reimbursement Arrangements (HRA)

An HRA is a tax-favored account that provides employer funding for out-of-pocket costs arising from claims. It is a promise to pay for services, and any unused funds remain with the employer. The statewide agreement allows the HRA to cover costs that are allowed by the health plan, and that are subject to cost-sharing, such as deductibles, copayments, or coinsurance. If the claim is eligible for the health plan, it will be paid by the HRA if there is a balance due from the patient, and there are funds available in the HRA.

Important Note: Non-covered services are **not** covered by the HRA, based on the statewide agreement. Examples of non-covered services include acupuncture, over-the-counter medications, dental or vision services, or cosmetic surgery.

Health Savings Account (HSA)

An HSA is also a tax-favored healthcare spending account. The terms of the statewide decision allow an employee the choice of an HSA (or HRA) for those who enroll in the Silver CDHP.

HSAs are not a promise to pay, like the HRA, but amounts are deposited into the HSA at the beginning of the calendar year, as required by the statewide decision. Once the deposit has been made to the HSA, the money belongs to the employee. Unused funds roll over year after year and can be used for qualified medical expenses at any time in the future, untaxed. Unlike the HRA, the HSA can be used for other services, such as dental, acupuncture, and vision. A list of qualified medical expenses can be found at **irs.gov/publications/p502/**.

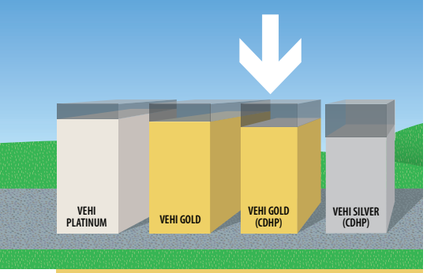
Important note: Employees must understand the requirements of the IRS relating to HSA eligibility, contributions, maximums, etc. before enrolling. Please review the **VEHI FAQ** at **vehi.org/faq** for information on eligibility and contribution rules.

How does the HRA work under the Statewide Bargaining Decision for Public School Employees?

The HRA is "first-dollar," which means that the employee is not required to pay for claims until the HRA has been exhausted. Medical and Pharmacy claims are handled differently. Each employee will receive an **HRA debit card** to use at the pharmacy. Medical claims are sent by your provider to Blue Cross VT for processing. After Blue Cross VT processes the claim, the cost-sharing information is sent to your HRA vendor electronically and any amount that is "due from patient" will be automatically paid out of your HRA to your provider on your behalf, until the HRA is depleted.

It is common to receive a bill from your medical provider before the HRA payment arrives at your provider's office. VEHI encourages you to monitor your claims on the **Blue Cross VT Member Resource Center** at **bluecrossvt.org/member-login** and your HRA vendor site, before paying for a service out of pocket. Please contact your human resources professional to learn more about your HRA vendor and how to access your information.

To compare plans, premiums and costs for each plan, please visit vehi.org/vehi-health-benefit-options/.



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)

- $1,750 if you have an individual plan
- $3,500 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

CDHP: Consumer Directed Health Plan

VEHI Gold Consumer-Directed Health Plan (CDHP) information

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 toward 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.

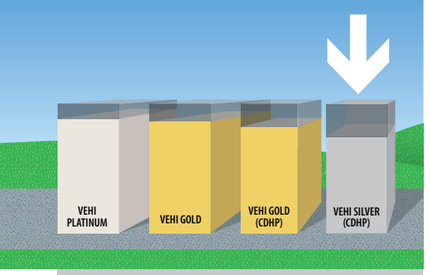
For an individual plan, you must meet the $1,750 prescription drug out-of-pocket limit before VEHI pays 100 percent of the allowed amount for prescription drugs.

If you're on a two-person, parent and child, or family plan, your entire family's combined expenses must meet the $3,500 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	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
mental health and substance abuse office visits		
specialist office visits may require prior approval		
maternity office visits		
chiropractic care prior approval required after 12 visits per year		
diagnostic services 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% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
HOME CARE AND REHABILITATION SERVICES		
inpatient skilled nursing or rehabilitation prior approval required for rehabilitation	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
home health and hospice care services prior approval required		
private duty nursing up to 14 hours per member per calendar year		
OTHER SERVICES		
ambulance prior approval required for non-emergency transport	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
medical equipment and supplies prior approval may be required		
vision exam one exam per year	$20 per exam	All but your copayment
PRESCRIPTION DRUGS		
prescription drugs (including home delivery) prior approval may be required	Deductible, then 20% coinsurance until you meet your prescription drug out-of-pocket limit of $1,750 for single plan and $3,500 for family coverage. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit of $1,750 for single plan and $3,500 for family coverage. After that, VEHI pays 100% of the allowed amount for the rest of the year. This is an aggregate out-of-pocket limit.
wellness drugs Visit **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 coinsurance. VEHI covers those drugs at 100% of the allowed amount.	100% of the allowed amount.



Compatible with HRAs and HSAs

General cost-sharing

(applies to most services before your plan provides benefits)

Deductible (stacked)

- $3,500 per individual
- $7,000 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)

- $1,750 if you have an individual plan
- $3,500 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

CDHP: Consumer Directed Health Plan

VEHI Silver Consumer-Directed Health Plan (CDHP) information

Understanding your deductible

This plan has a stacked deductible.

For individuals, you must meet the $3,500 deductible before VEHI begins paying benefits for applicable services.

If you're on a two-person, parent and child, or family plan, a covered family member may meet the individual deductible of $3,500 and begin receiving post-deductible benefits for their care. When your family's covered expenses reach the family deductible of $7,000, all family members receive post-deductible benefits.

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

Understanding your total out-of-pocket limit

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

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

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

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

Your plan has a lower out-of-pocket limit for prescription drugs. This prescription drug out-of-pocket limit accrues toward 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 $1,750 prescription drug out-of-pocket limit before VEHI pays 100 percent of the allowed amount for prescription drugs.

If you're on a two-person, parent and child, or family plan, your entire family's expenses combined must meet the $3,500 out-of-pocket limit, before VEHI pays 100% of the allowed amount for covered prescription drug expenses for the rest of the year.

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

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	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
mental health and substance abuse office visits		
specialist office visits may require prior approval		
maternity office visits		
chiropractic care prior approval required after 12 visits per year		
diagnostic services 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% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
HOME CARE AND REHABILITATION SERVICES		
inpatient skilled nursing or rehabilitation prior approval required for rehabilitation	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
home health and hospice care services prior approval required		
private duty nursing up to 14 hours per member per calendar year		
OTHER SERVICES		
ambulance prior approval required for non-emergency transport	Deductible, then 20% coinsurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
medical equipment and supplies prior approval may be required		
routine vision exam one exam per year	$20 per exam	All but your copayment
PRESCRIPTION DRUGS		
prescription drugs (including home delivery) Prior approval may be required.	Deductible, then 20% coinsurance until you meet your prescription drug out-of-pocket limit of $1,750 for single plan and $3,500 for family coverage. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit of $1,750 for single plan and $3,500 for family coverage. After that, VEHI pays 100% of the allowed amount for the rest of the year. This is an aggregate out-of-pocket limit.
wellness drugs Visit **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 coinsurance. VEHI covers those drugs at 100% of the allowed amount.	100% of the allowed amount.

Virtual Mental Health Support

Find the support you need virtually. Blue Cross VT has partnered with virtual providers to increase access to mental healthcare for Vermonters.

The services connect you with providers for such conditions as:

- Depression
- Anxiety
- Stress
- Insomnia
- Attention deficit hyperactivity disorder (ADHD)
- Post-traumatic stress disorder (PTSD)
- And more

Access virtual mental health support or schedule a consultation by visiting **bluecrossvt.org/mental-health-services**.

In-person Treatment

If you'd rather see a mental health provider face-to-face, start your search using our Find-A-Doctor tool at **bluecrossvt.org/find-doctor**.

- Enter your location and the type of provider you're looking for.
- Filter your search results by different categories like distance or gender.
- Click on a provider's name to see more information about them.

Other Options for Mental Health Support

You also have access to the Blue Cross VT case management team who are certified in mental health first aid. For more information, contact us:

- **Call:** (800) 922-8778, option 3
- **Email:** healthsupport@bcbsvt.com

Here are some other ideas for how to get help

- The National Suicide Prevention Lifeline is available in Vermont by dialing 988.
- Crisis Text Line is available 24/7 by texting "VT" to 741741
- Vermont Peer Support Line is available 24/7 by calling or texting 833-888-2557

If you have questions about your benefits or need help finding providers in our network, please give our customer service team a call at (800) 344-6690. We're available Monday to Friday from 7 a.m. – 6 p.m., except holidays. You can also log into your Member Resource Center account at **bluecrossvt.org/member-logins** to send us a secure email.

We have a variety of resources to help with your health and well-being.

Whole-Person Support, Every Step of the Way

Blue Cross's caring team of registered nurses, licensed social workers, and behavioral health counselors can provide you with one-on-one personal health support.

Addiction

Many Vermonters know someone who is affected by a substance use disorder. If you or a loved one struggles with addiction, please reach out for help. Our team can connect you to the providers, community, and care you need to achieve and sustain recovery.

Better Beginnings®

When you enroll in our maternal health program, you'll be partnered with one of our experienced Better Beginnings nurses. The nurse can coordinate your care and provide guidance — both during your pregnancy and after your child is born. We're available to answer your questions and give you information to help you make decisions about your pregnancy and growing family. You'll be able to use our mobile app to communicate directly with your Better Beginnings nurse. The app also includes a personalized health checklist to help you manage your day-to-day activities (see below on how to get the app).

After your baby has arrived, our Better Beginnings nurse can connect you to the support you need, such as a home health nurse, a lactation consultant, or other resources to help you meet your maternal health, wellness, and parenting goals.

Sign up before you are 34 weeks pregnant to take advantage of all the Better Beginnings benefits!

Contact our integrated case management team at **(800) 922-8778**, option 3; send an email to **healthsupport@bcbsvt.com**; or visit our **website** at **bluecrossvt.org/healthsupport**.

Cancer Care

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

Chronic Condition and Disease Management

Our team is standing by to guide you through dealing with long-term health conditions. These include asthma, COPD, diabetes, heart disease, seizures, rheumatoid arthritis, Crohn's, colitis, and many others.

End-of-Life

When facing end-of-life decisions, it is important to know the options and the available resources and support for you or your loved one.

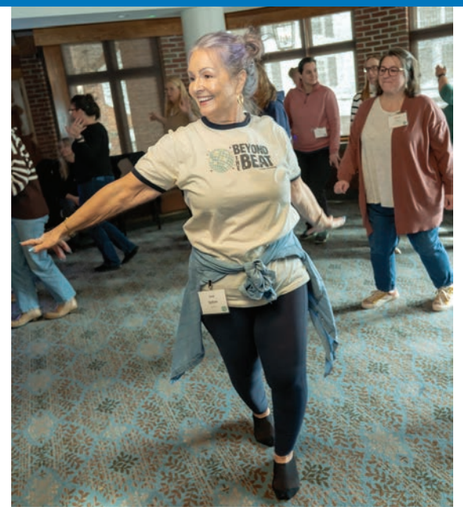
Mental Health

If you are struggling with anxiety, stress, depression, or other mental health conditions, you're not alone. Our team can connect you with professionals and resources to help you cope and feel better.

Gender Affirming Care

Questions about gender affirmation services? Call to be connected to one of our case managers who can provide expert guidance and coordination.

EMPLOYEE WELLNESS PROGRAM



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

- ✓ Create a VEHI PATH account or access the one you've already set up (**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 VT winter and summer outdoor events

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

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

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

PATH Community and Keeping Fit—This online tracking tool allows you to record your workouts, flexibility, and mindset all year. Join a team for added support or a bit of competition. Earn PATHpoints each month by recording 12 workouts in Keeping Fit.

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

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

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 10-week summer challenge is all about taking photos of some lighthearted family health goals, sharing them to your PATH account, 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—Sugar, mindfulness, emotional well-being, alcohol, and "Intuitive Eating" are some of the topics available in the online courses that support your wellbeing.

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

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

KNOW YOUR NUMBERS
Have your annual wellness visit.
25 points

QUIZZIFY
Safety and first aid tips made fun.
60 points

COMMUNITY AND KEEPING FIT
Online goal tracking.
120 points possible

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

SIZZLIN' SUMMER CHALLENGE
Friends and family fun.
25 points

PATH ADVENTURES
10-week challenge.
50 points possible

PROGRESS COACHING
Professional coaching for lasting change.
50 points possible

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

NOTICE OF PRIVACY PRACTICES

How Blue Cross VT 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 VT's privacy practices.

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

- Blue Cross VTs 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 VT's Notice of Privacy Practices is available at **bluecrossvt.org/privacy-policy**. Or you may request a paper copy by contacting Blue Cross VT's 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 VEHI's wellness programs. VEHI is an inter-municipal insurance association that is approved and overseen by the Vermont Department of Financial Regulation. VEHI offers non-insured, self-funded health benefit plans, wellness programs, and compliance services to schools and other educational organizations in Vermont. The enrollees of VEHI's health benefits plan are active and retired school employees and their dependents. VEHI's health benefit plans are financed by employer and/or employee contributions.

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

Generally, "protected health information" or "PHI" is information that relates to your past, present or future physical or mental health or condition (including your genetic information, as defined by federal law) the provision of healthcare to you, or the payment for that healthcare, 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 healthcare providers, for the care you receive. For example, we may provide information regarding your coverage or healthcare 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 healthcare 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 healthcare or reduce healthcare costs;
- clinical guideline and protocol development, case management and care coordination;
- contacting healthcare providers and participants with information about treatment alternatives and other related functions;
- competence or qualifications reviews and performance evaluations of healthcare 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 healthcare 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 management records we may have about you, as well as other records that we use to make decisions about your healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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.

DISCLAIMERS

General Exclusions

While your health plan covers a broad array of necessary services and supplies, it doesn't cover every possible medical expense. If you would like to review the list of general exclusions before enrolling, visit **bluecrossvt.org/contracts**, click on the plan in which you are enrolling and read the chapter entitled "General Exclusions." Once you enroll, you will receive an Outline of Coverage and a link to your Certificate of Coverage. Please read both carefully as they govern your specific benefits.

How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at **bluecrossvt.org/privacypolicies**.

NOTICE: Discrimination is Against the Law

Blue Cross® and Blue Shield® of Vermont (Blue Cross VT) 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, ethnicity, sexual orientation, or HIV-status.

Blue Cross VT 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).

Blue Cross VT provides free language services to people who speak or sign languages other than English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, contact the Civil Rights Coordinator at **civilrightscoordinator@bcbsvt.com**.

If you believe that Blue Cross VT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583 (TTY/TDD: 711), fax (802) 229-0511, or email **civilrightscoordinator@bcbsvt.com**. You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, the 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 or 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
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/ocr/complaints/index.html

For free language-assistance service, call (800) 247-2583 (TTY/TDD: 711).

ARABIC العربية	للحصول على خدمة المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583 (TTY/TDD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).
BOSNIAN BOSANSKI	Za besplatnu uslugu jezičke pomoći nazovite (800) 247-2583 (TTY/TDD: 711).
BURMESE မြန်မာဘာသာ	အခမဲ့ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုအတွက် (800) 247-2583 (TTY/TDD: 711) သို့ ဖုန်းခေါ်ပါ။
DARI دری	د وړیا ژبنی مرستې خدماتو لپاره، له (800) 247-2583 (TTY/TDD: 711) شمېرې سره اړیکه ونیسئ
FRENCH FRANÇAIS	Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/ TDD: 711).
KIRUNDI IKIRUNDI	Niba ukeneye ubwunganizi mu ndimi ku buntu, hamagara kuri (800) 247-2583 (TTY/TDD: 711).
NEPALI नेपाली	निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस् , (800) 247-2583 (TTY/TDD: 711). Niḥśulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583 (TTY/TDD: 711).
PASHTO پښتو	برای خدمات رایگان کمک زبانی، با شماره تماس (800) 247-2583 (TTY/TDD: 711) بگیرید
SIMPLIFIED CHINESE 简体中文	如需免费语言协助服务，请拨打 (800) 247-2583 (TTY/TDD: 711)。
SOMALI SOOMAALI	Si aad u hesho adeeg caawimo luuqadeed ah oo bilaash ah, wac (800) 247-2583 (TTY/TDD: 711).
SPANISH ESPAÑOL	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).
SWAHILI KISWAHILI	Kwa huduma ya usaidizi wa lugha bila malipo, piga simu kwa (800) 247-2583 (TTY/TDD: 711).
THAI ไทย	สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร, (800) 247-2583 (TTY/TDD: 711). Sǎhrạb brikār ch̀wyh̄elūx ḏān phāsʼā frī thor (800) 247-2583 (TTY/TDD: 711).
UKRAINIAN УКРАЇНСЬКА МОВА	Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583 (TTY/TDD: 711). Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583 (TTY/TDD: 711)
VIETNAMESE TIẾNG VIỆT	Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).

Notes

Notes

Contact Blue Cross VT or VEHI

Questions or need help with your health plan? Reach out to the local, award-winning customer service team at Blue Cross VT.

MAIL

Blue Cross VT

P.O. Box 186 | Montpelier, VT 05601-0186

Vermont Education Health Initiative

52 Pike Drive | Berlin, VT 05602

PHONE

Blue Cross VT
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 VT
bluecrossvt.org

Vermont Education Health Initiative
vehi.org

Pharmacy Network
bluecrossvt.org/vtbluerx

VEHI's health benefit plans are administered by:

BlueCross BlueShield of Vermont

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

Blue Cross and Blue Shield of Vermont

vehi

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

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