vehi

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.

Blue Cross and Blue Shield of Vermont's programs for VEHI members offer you…

- The freedom to choose your own doctors without having to get a referral
- Office visits and preventive care at a low cost to you
- The Blue HealthSolutions℠ program, including health management features, chronic care management, a free self-care guide, access to a 24-hour nurse hotline and an expansive health information website
- The Better Beginnings® prenatal program for expectant moms
- Member service staff available Monday through Friday, 7 a.m. to 6 p.m., and 24-hour, seven-day-a-week access via our website
- A nationwide network of participating providers
- The security of the Blue Cross and Blue Shield card—the most recognized symbol in health benefits worldwide
- World-class wellness programming offered by BCBSVT and VEHI PATH, featuring online tools, face-to-face sessions and much more

About this booklet

This booklet contains information about health benefit plans for active employees. Plan descriptions and information begin on page 18. This booklet summarizes the benefits and requirements of the plans offered. For full information, you must consult a BCBSVT subscriber contract. Once you enroll, you can see your contract documents on our member resource center or call our customer service team to request hard copies sent by mail. If you would like to read a contract document before you enroll, please visit the VEHI website at www.vehi.org. In the event of any discrepancies between this document and your contract, your contract documents prevail.

What is VEHI?

The Vermont Education Health Initiative (VEHI) is a large, non-profit purchaser of health care plans for Vermont's school employees. This self-funded, fully-insured purchasing trust is managed jointly by the Vermont School Boards Insurance Trust (VSBIT) and the Vermont-National Education Association (VT-NEA).

VEHI purchases health plans on behalf of Vermont's public school employees, including active and retired teachers, administrators, paraprofessionals, secretaries, custodians, bus drivers and all other school district employees.

VEHI's mission is to purchase high-quality health care services in a cost-effective manner on behalf of its members. As a voluntary consumer/purchaser alliance, VEHI plays an active role in all areas of health plan delivery, including design, financing, marketing, risk management, wellness, consumer education and customer service.

We at VEHI urge our members to view themselves as purchasers of health care rather than as beneficiaries of insurance. We believe that involving consumers directly in the purchasing of health care services provides the necessary link between providers and consumers that can ensure high-quality products and services at affordable prices.

Inside

VEHI Coverage

Coverage for active employees

VEHI offers the Dual Option Plan, which gives employees a choice between two of Blue Cross and Blue Shield of Vermont's programs:

- Vermont Health Partnership, a point-of-service plan (see page 18), and
- Comprehensive Plan, a fee-for-service program with a $300 deductible that applies to most services (see page 20)

VEHI also offers the following fee-for-service health care plans to its members:

- JY Plan (see page 22)
- Comprehensive Plan with no deductible (see page 24)
- Comprehensive Plan with $100 deductible (see page 24)
- Comprehensive Plan with $1,200 deductible (see page 24 and page 28)
- Consumer-Directed High-Deductible Health Plan (CDHP $1800) that can be paired with a health savings account (HSA) or health reimbursement account (HRA) (see page 26 and page 30)

All the plans offer virtually identical covered services. The variations occur in the plans' payment terms: each offers different member out-of-pocket arrangements.

Each group (school district) that purchases health benefit plans through VEHI chooses the plans offered to its members. For overviews of all of the plans VEHI offers, see the comparison chart on page 32 to 34.

Deductibles, co-payments and co-insurance

Our programs require different out-of-pocket cost-sharing arrangements for various services. For example, you may need to pay a co-payment for each visit for some services. These co-payments are not applied to your out-of-pocket maximums.

Other benefits require you to meet an annual deductible before we begin providing coverage. Each year, you may have a $300 deductible for most services, for example. In that example, once your expenses total $300 in a calendar year, we start to cover your care by paying 80 percent of our allowed amount in co-insurance. You pay the other 20 percent. Participating and network providers must accept our Allowed amount as payment in full. Once you meet your out-of-pocket limit (if your coverage has one), we cover your expenses at 100 percent of the allowed amount.

Look at the benefit summaries at the end of this booklet for more details on cost-sharing for the various plans VEHI offers.

Emergency care

We provide benefits for emergency care and other emergency treatment when we determine that your condition is a true emergency. We cover emergency care when a person with average knowledge of medicine would expect your condition to result in serious harm to your mental or physical health without immediate care.

You may need urgent care even when your condition is not an emergency. Your primary care physician can help you find this care in the most cost-effective, convenient setting.

Tips on other coverage

Your Certificate of Coverage and other subscriber contract documents give full details about your coverage. The benefit summaries beginning on page 18 give more information as well. Here are some important tips to keep in mind:

- In most programs, for mental health and substance abuse care, you must get prior approval from us by calling (800) 922-8778.
- We cover chiropractic care for neuromusculo-skeletal conditions. If you use more than 12 visits in a calendar year, your doctor must submit a treatment plan. You must use participating chiropractors in order to receive benefits. There is no coverage for non-participating chiropractic care.
- Be sure to read the sections on prescription drug coverage (page 8) and our prior approval program (page 6). You may have to use network providers to receive benefits. Your coverage does require your physician to get approval from us before using certain medications or services.

Information about new Vermont mandates

Vermont early childhood developmental delays mandate

The early childhood developmental delays mandate expands the age range for coverage of autism-related services up to 21 years of age. Coverage will expand to include diagnosis of developmental delays for autism spectrum disorders, Asperger's syndrome and pervasive developmental disorder.

Telemedicine

Beginning in October 2012 for all members, regardless of renewal date, BCBSVT provides benefits for some telemedicine services received at a facility, such as a skilled nursing facility or hospital. Telemedicine is the diagnosis, consultation or treatment of an individual through interactive audio and video. This benefit will be subject to the same cost-sharing arrangement (co-payment, deductible, etc) as for an in-person consultation.

Naturopath providers

As of July 2012, state law requires all health plans to consider naturopaths as an eligible primary care provider (PCP). BCBSVT has recognized naturopaths as PCPs since 2007.

Prescription out-of-pocket maximum

This mandate limits the amount members contribute toward the cost of their prescription drugs. State law sets a cap on out-of-pocket expenses at $1,250 for individual coverage or $2,500 for two-person or family coverage in 2013. Some VEHI plans already include limits lower than those prescribed by law. Others, for example CDHP plans, have had higher limits.

Members who have CDHP $1,800 deductible with a combined medical and drug out-of-pocket maximum, will now have a lower out-of-pocket limit that applies just to prescription drugs. The prescription out-of-pocket maximum is included in the total out-of-pocket maximum; it is not added to it.

The out-of-pocket limits are aggregated for two-person and family plans. For example, if you have two people on your plan, both of your expenses combined must meet the $2,500 out-of-pocket limit before we pay 100 percent. When expenses from all family members combined reach $2,500, we pay 100 percent of our allowed amount for all of your family members' drugs.

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 Certificate of Coverage.
- 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 Certificate of Coverage.
- Providers who are not approved to provide a particular service or who don't meet the definition of "provider" in your Certificate of Coverage.

If you would like to review our complete list of General Exclusions before enrolling, visit our website at **www.bcbsvt.com** and navigate to "Online Benefit Booklets." Once enrolled, you will have access to your Certificate of Coverage, which details all General Exclusions, on our Member Resource Center online. (If you would like a hard copy, please call our customer service team at the number on the back of your ID card.) Please read your Certificate of Coverage carefully; it is a part of your contract which governs your benefits.

How we protect 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 our privacy practices. A complete copy of our Notice of Privacy Practices is available at **www.bcbsvt.com.** Or to request a paper copy, contact our customer service team at the phone number listed on the back of your ID card.

Prior Approval

Our prior approval program

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

BCBSVT provides benefits for certain services, drugs and supplies only if you get prior approval. Network and participating physicians get prior approval for you. You must be sure your provider initiates prior approval if you use an out-of-network, non-participating provider. The services on the next page require prior approval regardless of the provider you choose: Please note that certain drugs also require prior approval. You may find a list on our website at **www.bcbsvt.com**.

Please call the member service number on the back of your BCBSVT ID card for help on how to obtain prior approval.

Our prior approval list changes periodically. BCBSVT lists the services that require prior approval in your contract materials. For the most recent prior approval list, visit **www.bcbsvt.com/priorapproval** or call the member services department at (800) 247-2583.

Type of Procedure	What Requires Prior Approval
Ambulance	All air or water ambulance transport and non-emergency ground ambulance
Anesthesia	Anesthesia for colonoscopy or endoscopy
Autism	Treatment of autism and developmental delays
Capsule Endoscopy	All services
Chiropractic	Chiropractic care after initial 12 visits in a calendar year
Chondrocyte Transplants	All services
Dental	Dental services—oral surgery, trauma and orthognathic surgery except oral lesion excision and biopsy
Durable Medical Equipment (DME)	Durable medical equipment with a purchase price over $500, including continuous positive airway pressure/bilevel positive airway pressure (CPAP/BIPAP) machines, vacuum-assisted closure of chronic wounds, external bone growth stimulators, oxygen and related supplies, nebulizers, hospital beds, wheelchairs and hospital-grade electric breast pumps (other than those provided through Better Beginnings®).
Genetic Testing	Most tests—those with Health Care Procedure Coding System (HCPCS) Codes between S3800 and S3890
Hyperbaric Oxygen Therapy	All services
Medical Nutrition for Inherited Metabolic Disease	Medical supplies and pumps, enteral formulae and parenteral nutrition
Mental Health and Substance Abuse Treatment	All services. Some contracts waive prior approval; please see your Certificate of Coverage for specifics.
New Medical Procedures	New procedures still considered investigational or experimental
Non-network services	All non-network services if you have a managed care plan
Osteochondral Autograft Transfer System (OATS)/Mosaicplasty	All services
Out-of-state Facility Care	All services
Plastic and Cosmetic Procedures	All services except breast reconstruction for patients with a diagnosis of breast cancer
Polysomnography (sleep studies) and Multiple Sleep Lateral Testing (MSLT)	All services
Prescription Drugs	Separate lists apply; please see Rx Center at www.bcbsvt.com/rxcenter
Prosthetics	All, regardless of cost
Radiology Services	All services. Examples include CT, MRI, MRA, MRS, PET and nuclear cardiology. Providers will work with American Imaging Management (AIM).
Rehabilitation	Rehabilitation at an inpatient facility
Surgery	Certain surgical procedures including bariatric (obesity) surgery, gastric electrical stimulation, percutaneous vertebroplasty, vertebral augmentation, temporomandibular joint manipulation/surgery and anesthesia and tumor embolization.
Transcutaneous Electrical Nerve Stimulation (TENS) Units/Neuromuscular Stimulators	All units require approval
Transplants (except kidney)	All services
UPPP/Somnoplasty	All services

Our Pharmacy Programs

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

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

Your out-of-pocket cost varies depending on the drugs you choose. Our three-tier program helps VEHI keep prescription drug costs down for you and for your health plan.

Three-tier drug program

Prescription drug prices are a contributing cause to increases in health care costs and insurance premiums. One way to substantially reduce medication costs is to use generic drugs whenever possible. Generics are less expensive than brand-name medications and are just as medically effective. In 2001, VEHI helped pioneer the tiered pharmacy benefit in Vermont that, through lower co-payment amounts for generic drugs, encouraged generic utilization by our members.

Rx co-payments

To promote greater utilization of generic medications, VEHI has eliminated the annual deductible and set the generic co-payment at only $5. Your benefit is now $0 deductible, per covered member per calendar year, then:

- $5 co-payment for generic drugs
- $20 for preferred brand-name drugs
- $45 for non-preferred brand-name drugs

The preferred brand-name Drug List can change and will be updated periodically to ensure that newer, more effective drugs are added. Drugs automatically come off the list when generic alternatives become available. Reduce your out-of-pocket expenses by asking your physician to authorize a generic substitution whenever possible. This guarantees you the lowest co-payment.

When a generic is not available, ask your doctor if one of the drugs on the Preferred Brand-name Drug List would be appropriate for you. These drugs can often meet patient needs at a lower cost. A list of Preferred Brand-name drugs is available at the Rx Center of our website, **www.bcbsvt.com/RxCenter**.

Convenient refills and savings with our home delivery program

If you use prescription drugs on an ongoing basis, our home delivery service may be a less expensive, more convenient way for you to buy prescriptions. If you use home delivery, you can get a 90-day supply of a drug for just two co-payments (rather than three). To begin using home delivery service for your maintenance drug, send our mail order pharmacy your doctor's prescription, an order form (available online or by phone) and your co-payment amount. To request refills, you may use a Web-based ordering system, **www.express-scripts.com**, or call the toll-free number, (877) 493-1949. (Narcotics and antibiotics are not available through the home delivery service.)

Over-the-counter drugs

We cover certain over-the-counter drugs, requiring only a generic-level co-payment from you. For example, if you take Claritin for allergies or Prilosec for stomach acid and reflux , you may ask for a prescription from your doctor. With that prescription, your pharmacist can dispense up to a 30-day supply of the medication and charge you just the co-payment you normally pay for generic drugs.

Our review of certain drug classes keeps costs down for you and your health plan

Prior approval

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

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

A complete list of drugs that require prior approval is available at the Rx Center of our website, **www.bcbsvt.com/RxCenter**.

Quantity limits

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

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

Step therapy

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

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

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

Better care through Blue HealthSolutions℠

Answers by phone or online

Whether you have a chronic condition or just need a first aid tip, our 24-hour nurse hotline provides easy access, at any time of the day or night, by phone. Call our registered nurses toll-free at (866) 612-0285.

Log on to our secure member site at **www.bcbsvt.com** to use our web tools, like the **Healthwise Knowledgebase®**, which contains thousands of pages of information about health topics on the Health Advisor, which helps you compare price and quality of care from various providers.

By using the tools on the My Blue Health® section of our site, you can create and manage a health improvement program designed especially for your specific needs— tracking your diet, exercise and overall health. My Blue Health features a number of exercise tools that allow you to track your physical activity, as well as gain access to fitness plans and exercise demos. You can use My Blue Health on your mobile device, making it easy to track while you're on the go.

My Blue Rewards

Health and Wellness Program℠

Our My Blue Rewards Health and Wellness program, with a launch date in fall, 2013, gives you discounts on area health, fitness, nutrition and wellness resources—even recreational activities in your community. To check out the growing list of discounted services and other items, visit **www.bcbsvt.com/mybluerewards**.

Disease management

Blue HealthSolutions helps members with a variety of conditions. They include:

- Diabetes (for members of all ages)
- Coronary artery disease (for members over age 18)
- Heart failure (for members over age 18)
- COPD (for members over age 18)
- Asthma (for members over age 18 who opt into the program)

We send you information about your condition and give you access to our nursing staff and other resources to help you make behavioral and lifestyle changes that are critical for your short- and long-term health improvement.

We may call you to discuss your condition. Our nurses want to be sure that you're getting the best care and screening available and help you comply with your doctor's treatment plan. Please know that our conversations with disease management participants are **strictly confidential** and that participation in the program is always **voluntary**.

Better Beginnings®

Expecting a new addition to the family? Our plans offer the Better Beginnings® program to help you make the healthiest, happiest start for your baby.

Better Beginnings uses health management tools to offer you pre-natal and post-natal support. When you enroll in the program, one of our Better Beginnings registered nurse case managers will work with you and your health care provider to promote healthy outcomes for you and your baby. You must register prior to the birth of your baby to participate.

Here's how it works!

You have a choice of five different benefit options if you register before 34 weeks gestation. (We have only a limited number of options for women who join after the 34th week of gestation.) A sample of benefits provided include but are not limited to:

- Homemaker services to help you after your baby is born
- Vouchers for car seats or fitness classes
- Coupons for birthing and infant/child CPR classes
- Your choice of a book from our specially selected Better Beginnings book list

A registered nurse case manager will review the program's benefits with you. Because every pregnancy is different, we tailor the program to meet your individual needs. You must actively participate in the program.

How to register

Go to our website at **www.bcbsvt.com/BetterBeginnings** and download all the forms you need to register in the "Quick Links" section on that page. You may also call the customer service number on the back of your ID card and a representative will help you get all the information you need to register.

Once you have your materials, please complete and return your health risk assessment, consent form and benefit option selection form to finish your registration.

Blue Cross and Blue Shield of Vermont reserves the right to change Better Beginnings options. You can always find the most recent options on our website at **www.bcbsvt.com/BetterBeginnings**.

Case management

Our case management program is a voluntary program. It is available in certain circumstances. Your case manager will work with you, your family and your provider to coordinate medical care for you.

Your case manager will help you manage your benefits. He or she may also find programs, services and support systems that can help. To find out if you are eligible for the program, call (800) 922-8778 and choose option 1.

Fitness and health promotion events at work or in your community

At Blue Cross and Blue Shield of Vermont, we care about the health of our members and our other neighbors and friends in Vermont. Each year, we hold many events that help Vermonters get up and moving. They range from National Walk@Lunch Day at Vermont schools and worksites to "Hike, Bike and Paddle" events at Vermont lakes and ponds to "Family Days" and "Snow Days" at some of our state's most beautiful venues.

While Blue Cross and Blue Shield of Vermont improves our members' health, we show our enthusiasm to your sons and daughters, too, through our sponsorship of "Girls on the Run" and "Velocity," our very own all-boys program. Be sure to check the community events section of our website or talk to your employer to see what we're doing in your area.

PATH Program from VEHI

Blue Cross and Blue Shield of Vermont and VEHI are committed to helping employers and employees function at their best. Blue Health Solutions, provided by BCBSVT, offers members online tools to help them manage their health while VEHI PATH, a 22-year-old, full-service workplace wellness program, offers members further depth in building and maintaining a healthy lifestyle, at work, at home and in your communities. In partnership with BCBSVT, VEHI PATH brings wellness to life for all its members.

VEHI PATH's mission is to support individuals like you in gaining skills, strategies and knowledge for living a healthy life in a healthy working environment. We want to see you "thriving" wherever you go!

VEHI helps you take Planned Action Toward Health—PATH, for short. VEHI PATH provides state-of-the-art health promotions services to help you address your entire well-being. Create a VEHI PATH account, or access the one you've already set up, and you're on your way (www.tomypath.com).

PATH Program from VEHI

Program services available to members, in addition to Blue Health Solutions, include the following:

PATH Adventures—our annual 10-week virtual fitness, healthy eating and stress management challenge. These themed adventures are championed by volunteer coordinators in every school district in Vermont. Here's what we've found each year:

- 93 percent report a significant increase in staff morale during the 10 weeks.
- 85 percent report at least one employee who makes a life-saving lifestyle change.
- 65 percent increase their physical activity; 59 percent feel healthier all-around; and 30 percent lost weight.

PATH Healthy Life Survey—A health risk assessment tool designed to spot your risks and help you celebrate your health achievements. When you're ready, this important snapshot of your health will help change your risks over time.

PATH community and keeping fit—participants track exercise workouts in six-month cycles and receive rewards for staying fit year-round! Teams help people build a sense of community around their goals and gain support for success.

Peer coaching course—An eight week course on giving and receiving mutual support for reaching a health-related goal.

Progress health coaching—Professional, clinical support for major life changes. If you're struggling with any health goal, set up a coaching appointment or two and you'll get a handle on the strategies that will be most effective to help you live your best life.

INVEST EAP—When life throws you a curve ball of stress, our clinical mental health counselors can direct you to the best resources possible. Deal with family, co-worker or parenting issues; find eldercare referrals, get legal or financial advice, or simply unload your burdens on a trained, friendly shoulder.

Thriving—Worksite health promotion consulting helps schools build a culture of wellness. Working with school administrators and wellness champions throughout the state to enhance your healthy working environment, Thriving helps address climate, norms, peer support, shared priorities and values on wellness and other strategies to help weave health into all aspects of your working world.

And much more…

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

The BlueCard® Program

Your coverage travels with you

When you're a BCBSVT member, you can take your health care benefits with you—across the country and around the world.

The BlueCard program gives you access to doctors and hospitals almost everywhere, giving you peace of mind because you can always find the care you need.

More than 85 percent of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield Plans. Outside of the U.S., you have access to doctors and hospitals in more than 200 countries.

By using Blue Cross and Blue Shield providers, you can take advantage of the savings that local Blue Plans have negotiated with the doctors and hospitals in their respective areas. You will not pay any amount above these negotiated rates. Also, you most likely will not have to complete a claim form or pay up front for health care services and wait for reimbursement. You will have to pay your out-of-pocket costs (like non-covered charges, deductibles, co-payments and co-insurance).

With the BlueCard program, you can locate doctors and hospitals quickly and easily. Have your Blue Cross and Blue Shield of Vermont ID card handy and either visit the BlueCard doctor and hospital finder website at **www.bluecares.com** or call **(800) 810-BLUE (2583)** for the names and addresses of doctors or hospitals in the area you're visiting.

Provider network

The VEHI program uses an expansive participating provider network in Vermont, as well as in other states and worldwide.

To find the most up-to-date list of participating providers, visit **www.bcbsvt.com** and click on the "Find a Doctor" link.

Our Vermont network includes well over 95 percent of the physicians in the state and all of Vermont's hospitals. Our pharmacy network includes virtually every Vermont pharmacy.

Membership Information

Open enrollment/ Changing plans

Please note that this section has been revised because federal rules require open enrollment periods be aligned with an employer's Section 125 (Cafeteria) Plan year. Previously, VEHI provided two open enrollment periods, January 1 and July 1.

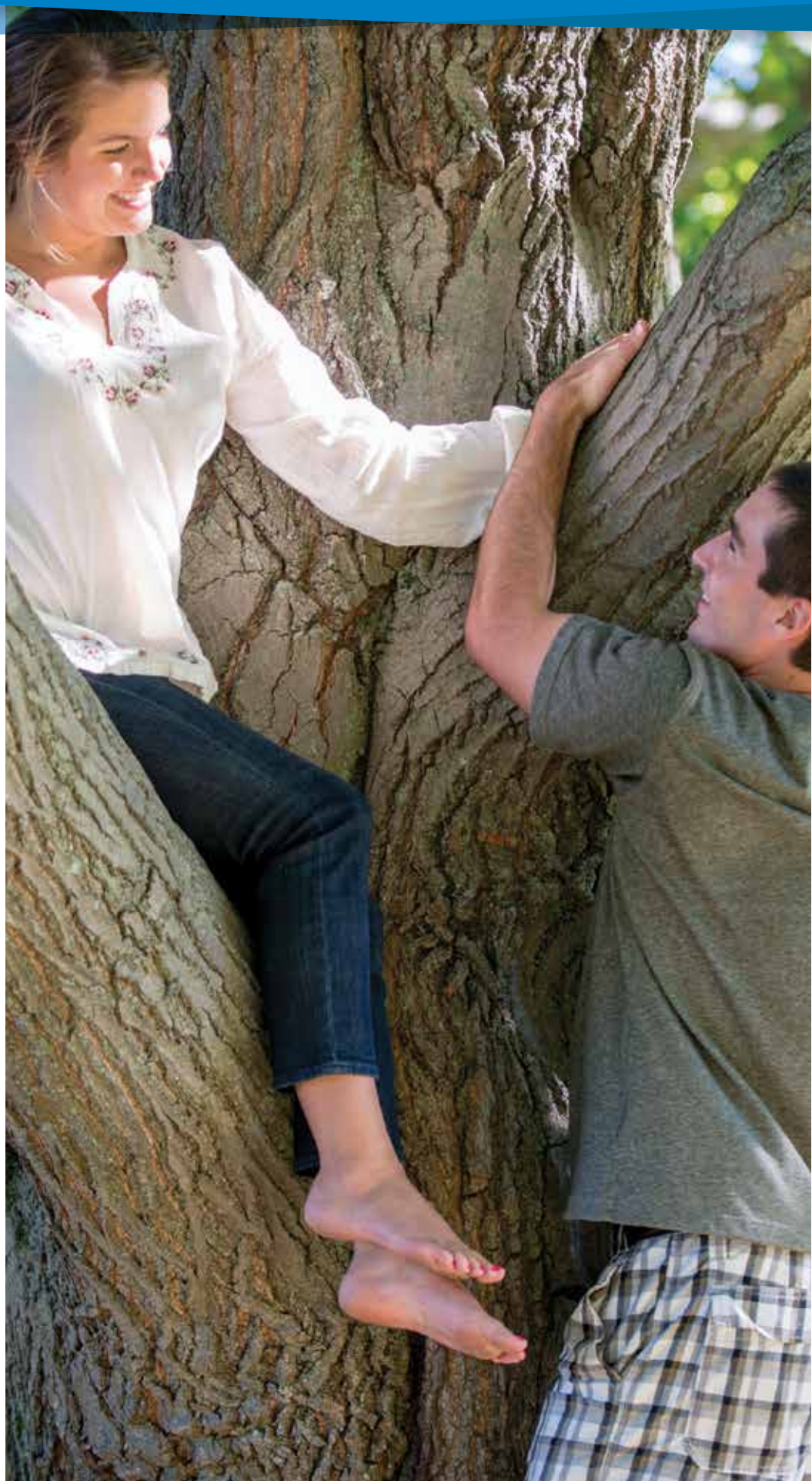
Your employer is limited to just one annual open enrollment period, during which time you may:

- 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 your group offers more than one health plan.

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

This is the only time you can make these changes unless you and/or your eligible dependents experience a change in life status (for example, a birth or loss of coverage). For more information regarding change-in-status events, inquire with your school district or go to page 15 of this booklet.

We also advise you to contact your school district to determine when your group's open enrollment period takes place.



Marriage/civil union

When you marry or enter a civil union, you may add your partner and his or her dependents to your membership. If we receive your application within 31 days after the date of marriage or civil union, your new type of membership is effective the first day of the month following the date of marriage or civil union. If we receive your request within 32 to 60 days after the date of your marriage or civil union, your new membership becomes effective the first day of the month after we receive your request. Your new dependent or dependents 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 new dependent within 60 days of your marriage or civil union, you must wait until an open enrollment date to do so.

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

Birth or adoption

If you already have a family membership, we cover your new child from the date of birth, legal placement for adoption or legal adoption. You should, however, notify us of your family addition within 31 days.

If you do not have a family membership, we cover your child for 31 days after:

- birth;
- legal placement for adoption (when placement occurs prior to adoption finalization);

or

- legal adoption (when placement occurs at the same time as adoption finalization).

We must receive your application for a membership change in order to continue benefits for the child past 31 days. If we receive your request within the 31 days, the child's effective date is retroactive to the date of birth, placement for adoption or adoption. The new type of membership is effective the first day of the month following birth, placement for adoption or adoption.

If we receive your request within 32 to 60 days, the child's membership and the new type of membership are effective the first day of the month following our receipt of your request. You may enroll your new dependent or dependents on your current plan, or you and your dependents may change to any other plan your employer offers.

If you fail to add your new dependents within 60 days, you must wait until an open enrollment date to do so. Dependents who do not become covered within 94 days must fulfill their own waiting periods for pre-existing conditions.

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

Dependent's loss of coverage

Any dependents covered under health coverage with another health plan are eligible for membership under your contract if they lose health coverage or terminate employment. Within 31 days after loss of coverage, a 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 they lose coverage, you must wait until an open enrollment date to do so.

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

Court-ordered dependents

The effective date of a court-ordered addition of a dependent is the first of the month after we receive your request. The request must include proof of the court order.

Special enrollment rights under "CHIP"

Effective April 1, 2009, 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 in two situations:

- When employees lose eligibility for Medicaid, Vermont Health Access Program (VHAP) or Dr. Dynasaur; or
- When employees become eligible for Vermont's Employer Sponsored Insurance (ESI) premium subsidy program.

You must request coverage no later than 60 days after losing coverage from Medicaid, VHAP or Dr. Dynasaur or when the State determines you are eligible for premium assistance. You may choose either the date coverage ends or the first of the month following 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.

Please contact your group benefits manager for more information.

Frequently Asked Questions

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

   The covered medical services in the Comprehensive options are identical to those in the JY plan. If you select the Vermont Health Partnership POS option (VHP), the covered services are virtually identical. The only additional benefit the VHP POS plan offers is for an annual vision exam.

2. **What are the key differences between the JY plan and the $300 Comprehensive plan?**

   The key difference between JY and the $300 Comprehensive plans is the way they pay for the services they cover.

   The JY plan covers most necessary services at 100 percent of the allowed amount. You pay only a $20 co-payment for each office visit, including mental health and chiropractic visits. For certain services, such as ambulance, private duty nursing or medical equipment and supplies, you must pay a $100 deductible and then 20 percent of the allowed amount in co-insurance up to $600 per calendar year. Co-payments you pay for office visits do not apply to this out-of-pocket maximum.

   Under the $300 Comprehensive plan, you must first meet your $300 deductible. Then, we pay 80 percent co-insurance for covered services. Your maximum individual out-of-pocket expense under this plan is also $600: a $300 deductible and $300 in co-insurance expenses. See page 20 for details.

   Both plans offer the same Three-tier Prescription Drug plan. Refer to page 8 for details.

3. **How does VHP differ from fee-for-service plans?**

   The Vermont Health Partnership is a point-of-service plan. In this type of plan, your Primary Care Physician (PCP) manages your care, handles routine or preventive care needs and may direct you to specialty providers when you need further care. When you visit your Primary Care Physician, you pay only $15 per visit. For visits with a VHP network specialist, you pay $25 per visit. One co-payment covers all prenatal and postnatal visits with a VHP network OB/GYN provider.

4. **Can some family members select the $300 Comprehensive plan while others select another plan?**

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

5. **If I choose the $300 Comprehensive plan at first, can I later change my mind and move into the VHP option?**

   Yes. Regardless of which plan you initially select, you may change plans once in a 12-month period, on either January 1 or July 1, in accordance with plan guidelines (see "Changing Plans" on page 14). You must give written notice to BCBSVT at least 30 days prior to the date you will be changing options. See representatives from your district's business office for the forms you need.

6. **What types of doctors are usually considered Primary Care Physicians under the VHP option?**

   Pediatricians, general practitioners, internists, naturopaths and family practitioners are Primary Care Physicians. Some Advanced Practice Registered Nurses may also serve as PCPs. You can find a list of PCPs on our website at **www.bcbsvt.com**.

7. **Are all Vermont Primary Care Physicians participating in the VHP network?**

   Most are. In order to join the network, a Primary Care Physician must apply and be credentialed by BCBSVT. Presently, 85 percent of in-state BCBSVT Primary Care Physicians are in the VHP network. Many New Hampshire doctors along the Connecticut River, and some in New York, are also in the VHP network. You can always find the most current list of Primary Care Physicians in the "Find a Doctor" section of our website at **www.bcbsvt.com**.

8. **What if my present primary care doctor isn't in the VHP network? What are my options?**

   First, ask your doctor why, and then urge him or her to apply. By doing so, you can help BCBSVT expand the list of network Primary Care Physicians. Second, you could consider picking a different Primary Care Physician who is in the network. Remember, while you do not need a referral from your Primary Care Physician for specialty care, you do need to use your Primary Care Physician for your primary care needs. Finally, you may consider another health plan option if your school district offers more than one. The list of Primary Care Physicians continues to grow, so you should regularly consult the most current listing. Call member service at (800) 247-2583 to get a current list or log onto our website at **www.bcbsvt.com**.

9. **If I select the VHP plan, can I designate a different Primary Care Physician for each member of my family?**

   Yes, each family member may designate a different Primary Care Physician. Any children away at college and covered by your VHP plan must also designate a Primary Care Physician from the VHP network.

10. **In my area, most of the Primary Care Physician practices are closed to new patients. What should I do?**

    Although the Directory of Primary Care Physicians lists many physician offices as closed, openings occur from week to week. Consider calling the practice directly to inquire about recent openings. Or use our Find-a-Doctor tool online and select a Primary Care Physician who is accepting new patients.

11. **How often can I change my Primary Care Physician under VHP?**

    We encourage you to develop a long-term relationship with your Primary Care Physician. However, should you need to change physicians, you may do so as often as once a month. Changes become effective the first of the month following the date BCBSVT receives your request to change. BCBSVT strongly encourages you to provide notice, by phone or in writing, by the 15th of the month in order to properly notify your new Primary Care Physician that you will be coming under his or her care for the upcoming month. Please note that we cannot make retroactive changes.

12. **If I select the VHP plan, when do I need my Primary Care Physician's referral?**

    It is not necessary for your Primary Care Physician to submit a written referral to BCBSVT. We encourage you to contact your Primary Care Physician before seeking specialty care to ensure you get the correct level of care. Be sure to use a network provider, or Standard Benefits may apply.

13. **If I choose the VHP option, do I need to contact my Primary Care Physician if I need care out of state?**

    If you are facing a medical emergency, seek care immediately. Contact your doctor as soon as possible afterward to coordinate follow-up

care. Such emergencies never require advance approval, although you must notify BCBSVT within 48 hours if you are admitted to the hospital. For out-of-state care in non-emergency situations, your doctor may help you request prior approval from BCBSVT if you wish to receive preferred benefits. Otherwise, standard benefits may apply.

14. Are adult dependent children covered?

Yes. Generally, dependents can be covered until age 26. If your child no longer lives at home or is away at school, he or she may still receive benefits through your plan.

15. Are dependent children on VHP covered for emergency and non-emergency out-of-area care?

Yes. The VHP plan pays preferred benefits without prior approval for emergency care out of area needed by students and other dependents.

For routine or non-emergency care out of area, including care that requires ongoing therapy, students and other dependents on VHP need to get prior approval. Out-of-area care may be covered by standard benefits if they don't get prior approval (for instance, if BCBSVT determines that care could be delivered in-network). For some services, you may not receive standard benefits (see the chart on page "Standard Benefits" on page 19 for details).

Whenever possible, students and out-of-state dependents with VHP coverage should schedule primary care and specialty care visits while at home visiting or on break. When that is not possible, out-of-area dependents in VHP (and other VEHI plans) are advised to get care through a provider that participates with another BCBS plan. You can than take advantage of rates negotiated by our sister plans.

16. How does my coverage work in emergency situations?

Emergency room treatment must meet the criteria in your Certificate of Coverage to be covered by any VEHI plan. No matter which plan you choose, it's also wise to inform your primary care doctor when you've received emergency care. He or she will want to coordinate necessary follow-up care and ensure you get the appropriate treatment. If you are admitted to the hospital, be sure to call BCBSVT for precertification to protect you from having to pay for unnecessary and non-covered hospital stays.

17. What is the difference between preferred and standard benefits?

"preferred" and "standard" refer to levels of reimbursement for services covered by the Vermont Health Partnership. To find out how to obtain maximum (or "preferred") benefits, please see the chart on page 19.

18. How do the different plans provide services for mental health and substance abuse care?

Most VEHI plans offer access to mental health and substance abuse services (MH/SA) only in a managed care setting. This means treatment is approved and directed by the clinical staff at BCBSVT. New for 2013, your mental health and substance abuse care management will be integrated with management of other care.

You can easily secure initial authorization by calling the prior approval number on the back of your ID card. None of the plans offered requires you to get a referral from your Primary Care Physician before seeking care. Network representatives will approve services and direct you to a network provider in your area who can provide the type of care you need.

Depending on local, negotiated agreements, your MH/SA benefits may differ from those described in this brochure. Call your school's business office if you have further questions.

19. How are dental services covered under the plan?

All plans offered require you to get prior approval for dental services other than extraction of wisdom teeth (see page 6). Covered dental services include only the procedures listed below:

- treatment for accidental injury to the jaws, teeth, mouth or face;
- surgery to correct gross deformity resulting from major disease;
- surgical removal of bone-impacted teeth; and
- treatment of temporomandibular joint syndrome.

20. My daughter just turned 26 and has purchased my existing plan under COBRA. Does she have other health plan choices in addition to the plan I've chosen?

Yes. According to COBRA regulations, unless she decides to waive COBRA and purchase a different plan outside of your group, she can select from any of the plan options offered by your employer. She is eligible for coverage for up to 36 months. She may also be eligible for coverage on Vermont Health Connect and may qualify for subsidies to help pay premiums.

21. My benefit summary says my plan is "grandfathered." What does that mean?

The Affordable Care Act (ACA), passed by the federal government, was signed into law on March 23, 2010. It mandated a number of reforms for health insurance plans. Many of these reforms apply to all health plans. Some provisions, however, apply only to plans that were created after March 23, 2010, or were first offered to employees after this date. These plans are non-grandfathered. Plans that existed or were offered to employees before March 23, 2010, on the other hand, are grandfathered.

So, if your school offered particular VEHI plans before March 23, 2010, like the Dual Option Plans, for example, those plans are considered grandfathered. If it offered a new plan for the first time after March 23, 2010, for instance the $1,000 Comp (now the $1,200 Comp), that plan would be non-grandfathered. So a school district could make available to employees at the same time both grandfathered and non-grandfathered plans.

- Grandfathered plans may keep their current preventive care benefits with existing cost-sharing arrangements, while non-grandfathered plans must include preventive care with no member cost-sharing. Non-grandfathered plans, according to the ACA, must offer coverage at 100 percent for any service or supply defined as preventive by the United States Preventive Services task force.

Check the benefit summaries at the end of this booklet to see the differences between grandfathered and non-grandfathered plans.

Grandfathered Dual Option: Vermont Health Partnership

Preferred Benefits	What You Pay	How to Obtain Preferred Benefits
In the Primary Care Physician's Office ▪ Well-child care, immunizations and physical examinations ▪ Lab, X-rays, allergy tests, other diagnostic services ▪ Care for urgent problems, day or night ▪ Surgery, casts, dressings administered in the office	▪ $15 co-payment ▪ For surgery in the office, one co-payment covers all pre- and post-operative visits	▪ Pick a Primary Care Physician for yourself and each covered family member and use that doctor. The most current listing of Primary Care Physicians is available on our website at www.bcbsvt.com.
In the specialty provider's office ▪ Care by all specialists who participate with BCBSVT (for example, cardiologist, oncologist, OB/GYN, chiropractor, mental health provider) ▪ Certain short-term therapies (e.g. physical, speech, occupational)	▪ $25 co-payment	▪ Use a network specialty provider or get prior approval (see page 6) from BCBSVT. ▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.
OB-GYN office visits ▪ Gynecological care ▪ Pre-natal and post-natal maternity care	▪ $25 co-payment ▪ One co-payment covers all prenatal and postnatal maternity visits	▪ Use a network OB/GYN provider or get prior approval from BCBSVT.
Inpatient Care in a Hospital ▪ Appropriate room and board accommodations ▪ All covered physicians' services, including surgery ▪ Maternity care for mother and child ▪ Laboratory, diagnostic and X-ray services ▪ Drugs and medications received as an inpatient ▪ Therapy services	▪ Covered in full	▪ Call for Preadmission or Admission Review. ▪ Use a network hospital or get prior approval to use an out-of-network provider. (See prior approval Program on page 6.) ▪ See below for mental health and substance abuse treatment benefits.
Hospital Emergency Care Covered only if your symptoms are severe enough that the absence of immediate medical attention could reasonably be expected to: ▪ place your physical or mental health in serious jeopardy; or ▪ cause serious impairment to bodily functions; or ▪ cause serious dysfunction of any bodily organ or part.		▪ Your condition must meet the criteria for an Emergency Medical Condition in your Certificate. See page 4 in this booklet for details.
Hospital Outpatient Care ▪ Outpatient surgery ▪ Lab, X-rays, EKG and other diagnostic services		▪ You may need prior approval (see page 6).
Hospital Outpatient Care ▪ Certain short-term therapies (e.g. physical, speech, occupational)		▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.
Ambulance In or Out of Service Area ▪ Ambulance service to the nearest facility in an emergency ▪ Non-emergency transfer between facilities	▪ $50 co-payment ▪ Limited to one co-payment per person, per day	▪ For emergency transport benefits, your condition must meet the criteria for an emergency medical condition in your Certificate. ▪ Non-emergency treatment requires prior approval.
Home Care ▪ Skilled nursing visits, short-term therapy delivered in your home ▪ Private duty nursing	▪ $25 co-payment for private duty nursing ▪ All other home care is covered in full	▪ We limit private duty nursing benefits to 14 hours per calendar year.
Chiropractic Care ▪ Services to treat a neuromusculoskeletal condition	▪ $25 co-payment	▪ You must use a network chiropractor. ▪ There are no Standard Benefits for these services. ▪ You need prior approval for any visits after 12 in a calendar year.

Preferred Benefits	What You Pay	How to Obtain Preferred Benefits
Mental Health and Substance Abuse Treatment ▪ Inpatient care ▪ Outpatient visits	▪ Covered in full ▪ $25 co-payment	▪ You need prior approval. Call the prior approval number on the back of your ID card to initiate treatment.
Prescription Drugs ▪ Prescription drugs and antigens prescribed by a physician for FDA-approved uses ▪ Diabetic supplies (e.g., test strips, insulin and syringes)	▪ $0 annual prescription drug deductible, then ▪ a $5 co-payment for generic drugs, or ▪ a $20 co-payment for Preferred Brand-name drugs, or ▪ a $45 co-payment for Non-preferred Brand-name drugs. ▪ Out-of-pocket maximums for prescription drugs are $600 per individual or $1,200 for a family.	▪ Use a network pharmacy. There are no Standard Benefits for this service. ▪ You need prior approval before you buy certain drugs. See page 9 for details. ▪ See page 9 for details about how to save money with the convenient mail order service.
Medical Equipment and Supplies ▪ Supplies and equipment that have no non-medical use.	▪ $100 annual medical equipment and supplies deductible, then ▪ 20 percent co-insurance	▪ Use a network provider. There are no Standard Benefits for this service. ▪ Your $100 medical equipment and supplies deductible is separate from your Standard Benefits deductible (see below). Your medical equipment and supplies deductible and co-payments **do not** count toward your medical out-of-pocket limit. ▪ See description of prior approval program on page 6.
Vision Exams ▪ Exam to determine visual problems and prescribe any necessary lenses. Limit: one exam per member per calendar year.	▪ $20 co-payment ▪ No coverage for evaluation, prescription or fitting of contact lenses	▪ Use a Vision Service Plan network provider. There are no Standard Benefits for this service.

Standard Benefits

For some services, the Vermont Health Partnership provides a second "Standard" level of benefits if you fail to follow guidelines for Preferred Benefits (shown in the right hand column above). In these circumstances, you must share in the higher cost of your care. For Standard Benefits, you must pay:

- an annual $500 individual deductible for all Standard Benefits services (or a $1,000 deductible for all family members' Standard Benefits deductible services combined), then
- 30 percent of the Allowed amount for all Standard Benefits services after you meet your deductible until you meet your out-of-pocket limit of $2,500 per individual or $5,000 per family for Standard Benefits* each calendar year.

After you reach your out-of-pocket maximum, we pay 100 percent of the allowed amount for the rest of the calendar year.

Please note that for many services, we do not provide Standard Benefits. They include:

- chiropractic care
- nutrition counseling
- prescription drugs
- primary care physician services
- rehabilitation
- vision exams
- medical equipment and supplies

If you fail to follow the Preferred Benefits guidelines above, we provide no coverage at all.

* Prescription drug and medical equipment deductibles and co-payments that you pay when you receive Preferred Benefits are not applied to your out-of-pocket limits.

Grandfathered Dual Option: $300 Deductible Comprehensive Plan

formerly the $250 Comprehensive Dual Option Plan

Covered Services	What You Pay	How to Obtain Benefits
In the Doctor's Office ▪ All physicians' visits, including preventive care and well-child care ▪ Lab, X-rays, allergy tests, other diagnostic services ▪ Care for urgent problems, day or night ▪ Routine immunizations and physical examinations ▪ Surgery, casts, dressings administered in the office ▪ Care by specialists (for example, cardiologists, oncologists) ▪ Certain short-term therapies (e.g. physical, speech, occupational)	▪ Your $300 individual or $600 family deductible, then ▪ 20 percent of the allowed amount up to your $600 individual or $1,200 family out-of-pocket limit ▪ After you meet your out-of-pocket limit, you pay nothing	▪ Use Participating providers. If you use non-participating providers, your out-of-pocket expenses may be much higher. ▪ See prior approval program description on page 6. ▪ See next page for a description of your mental health and substance abuse benefits. ▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.
OB-GYN Office Visits ▪ Gynecological care ▪ Pre-natal and post-natal maternity care		▪ Use a Participating OB/GYN provider. You may pay more out-of-pocket if you use a Non-participating provider.
Inpatient Care in a Hospital ▪ Appropriate room and board accommodations ▪ All covered physicians' services, including surgery ▪ Maternity care for mother and child ▪ Laboratory, diagnostic and X-ray services ▪ Drugs and medications received as an inpatient ▪ Therapy services		▪ You must comply with the Precertification program requirements by calling for Preadmission or Admission Review. ▪ See prior approval Program description on page 6. ▪ See next page for a description of your mental health and substance abuse treatment benefits.
Hospital Emergency Care Emergency room care is covered only if your symptoms are severe enough that the absence of immediate medical attention could reasonably be expected to: ▪ place your physical or mental health in serious jeopardy; or ▪ cause serious impairment to bodily functions; or ▪ cause serious dysfunction of any bodily organ or part.		▪ You may pay more out-of-pocket if you use a non-participating provider.
Hospital Outpatient Care ▪ Outpatient surgery ▪ Lab, X-rays, EKG and other diagnostic services ▪ Certain short-term therapies (e.g. physical, speech, occupational)		▪ Use a Participating provider. You may pay more out-of-pocket if you use a Non-participating provider. ▪ See description of prior approval program on page 6. ▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.
Ambulance In or Out of Service Area ▪ Ambulance service to the nearest facility in an emergency ▪ Non-emergency transfer between facilities		▪ Your condition must meet the criteria for an Emergency Medical Condition in your Certificate. ▪ A transfer to another facility is covered when necessary to meet the patient's needs, but not covered when it is the patient's or provider's preference.

Covered Services	What You Pay	How to Obtain Benefits
Home Care ▪ Skilled nursing visits, short-term therapy delivered in your home ▪ Private duty nursing	▪ Your $300 individual or $600 family deductible, then ▪ 20 percent of the allowed amount up to your $600 individual or $1,200 family out-of-pocket limit. ▪ After you meet your medical out-of-pocket limit, you pay nothing.	▪ You may pay more out-of-pocket if you use a non-participating provider. ▪ We limit private duty nursing benefits to 14 hours per calendar year.
Chiropractic Care ▪ Services to treat a neuromusculoskeletal condition		▪ You must use a participating chiropractor. We do not cover services by non-participating chiropractors. ▪ You need prior approval for any visits after 12 in a calendar year.
Mental Health and Substance Abuse Treatment ▪ Inpatient care ▪ Outpatient visits		▪ You need prior approval. Call the prior approval number on the back of your ID card to initiate treatment.
Prescription Drugs ▪ Prescription drugs and antigens prescribed by a physician for FDA-approved uses ▪ Diabetic supplies including test strips, insulin and syringes	▪ $0 annual prescription drug deductible, then ▪ a $5 co-payment for generic drugs, ▪ a $20 co-payment for Preferred Brand-name drugs, or ▪ a $45 co-payment for Non-Preferred Brand-name drugs. ▪ Out-of-pocket maximums for prescription drugs are $600 per individual or $1,200 for a family.	▪ Use a network pharmacy. We do not cover prescription drugs you purchase at an out-of-network pharmacy. ▪ See page 9 for details about how to save money with the convenient mail order service. ▪ You need prior approval before you buy certain drugs. See page 9 for details about the Prior Approval program. ▪ Your prescription co-payments **do not** count toward your medical out-of-pocket limit.
Medical Equipment and Supplies ▪ Supplies and equipment that have no non-medical use	▪ Your $300 individual or $600 family deductible, then ▪ 20 percent of the allowed amount up to your $600 individual or $1,200 family out-of-pocket limit. ▪ After you meet your medical out-of-pocket limit, you pay nothing.	▪ You may pay more out-of-pocket if you use a Non-participating provider. ▪ See description of prior approval program on page 6.
Vision Exams	▪ No benefits	▪ No benefits

Grandfathered JY Plan

Covered Services	What You Pay	How to Obtain Benefits
Office Visits ▪ Preventive care and well-child care ▪ Care by a specialist (for example, cardiologist, oncologist, OB/GYN, chiropractor, mental health provider) ▪ Emergency room physician	▪ $20 co-payment	▪ See next page for a description of your mental health and substance abuse benefits. ▪ You may pay more out-of-pocket if you use a non-participating provider. ▪ Mental health and substance abuse treatment may require prior approval.
Other Physicians' Services ▪ Medical care and physicians' visits while you're an inpatient ▪ Certain short-term therapies (e.g. physical, speech, occupational) ▪ Labs, X-rays, allergy tests, other diagnostic services ▪ Care for urgent problems, day or night ▪ Surgery, casts, dressings administered in the office ▪ Pre-natal and post-natal maternity care	▪ $0 (covered at 100 percent of the allowed amount)	▪ You may pay more out-of-pocket if you use a non-participating provider. ▪ See prior approval program description on page 6. ▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.
Inpatient Care in a Hospital ▪ Appropriate room and board accommodations ▪ Maternity care for mother and child ▪ Hospital charges for therapy, laboratory, diagnostic and X-ray services ▪ Drugs and medications received ***as an inpatient***		▪ Call for Preadmission or Admission Review. ▪ See prior approval program description on page 6. ▪ Mental health and substance abuse treatment may require prior approval.
Hospital Emergency Care Emergency room care is covered only if your symptoms are severe enough that the absence of immediate medical attention could reasonably be expected to: ▪ place your physical or mental health in serious jeopardy; or ▪ cause serious impairment to bodily functions; or ▪ cause serious dysfunction of any bodily organ or part.		▪ You may pay more out-of-pocket if you use a non-participating provider.
Hospital Outpatient Care ▪ Outpatient surgery ▪ Lab, X-rays, EKG and other diagnostic services ▪ Certain short-term therapies (e.g. physical, speech, occupational)		▪ You may pay more out-of-pocket if you use a non-participating provider. ▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined. ▪ See description of prior approval program on page 6.
Home Care ▪ Skilled nursing visits, short-term therapy delivered in your home		▪ You may pay more out-of-pocket if you use a Non-participating provider.

Covered Services	What You Pay	How to Obtain Benefits
Private Duty Nursing	▪ $100 JY Plan deductible,* then ▪ 20 percent of the allowed amount up to your $600 out-of-pocket limit. ▪ After you meet your out-of-pocket limit, you pay nothing.	▪ We limit private duty nursing benefits to 14 hours per calendar year.
Ambulance In or Out of Service Area ▪ Ambulance service to the nearest facility in an emergency ▪ Non-emergency transfer between facilities		▪ Your condition must meet the criteria for an Emergency Medical Condition in your Certificate. ▪ Transfer to another facility is covered when necessary to meet the patient's needs, but not covered when ambulance service is chosen solely according to the patient's or provider's preference.
Chiropractic Care ▪ Services to treat a neuromusculoskeletal conditions	▪ $20 co-payment	▪ You must use a participating chiropractor. We do not cover services by non-participating chiropractors. ▪ You need prior approval for any visits after 12 in a calendar year.
Mental Health and Substance Abuse Treatment ▪ You may have to call to initiate treatment.	▪ Outpatient care: $20 co-payment ▪ Inpatient care: $0	▪ You need prior approval. Call the prior approval number on the back of your ID card to initiate treatment.
Prescription Drugs ▪ Prescription drugs and antigens prescribed by a physician for FDA-approved uses ▪ Diabetic supplies including test strips, insulin and syringes	▪ $0 annual prescription drug deductible, then ▪ a $5 co-payment for generic drugs, or ▪ a $20 co-payment for Preferred Brand-name drugs, or ▪ a $45 co-payment for Non-preferred Brand-name drugs. ▪ Out-of-pocket maximums for prescription drugs are $600 per individual or $1,200 for a family.	▪ Use a network pharmacy. We do not cover prescription drugs you purchase at an out-of-network pharmacy. ▪ See page 9 for details about how to save money with the convenient mail order service. ▪ You need prior approval before you buy certain drugs. See page 9 for details about the prior approval program. ▪ Your prescription drug co-payments **do not** count toward your medical out-of-pocket limit.
Medical Equipment and Supplies ▪ Supplies and equipment that have no non-medical use	▪ $100 JY Plan deductible,* then ▪ 20 percent of the allowed amount up to your $600 out-of-pocket limit. ▪ After you meet your out-of-pocket limit, you pay nothing.	▪ You may pay more out-of-pocket if you use a Non-participating provider. ▪ See description of prior approval Program on page 6.
Vision Exams	▪ No benefits	▪ No benefits

** Note: This plan includes a JY Plan (general) deductible for services such as ambulance and private duty nursing, and the general deductible and the co-insurance apply to the out-of-pocket limit.*

Other Grandfathered Comprehensive Options

($0, $100 or $1,200 Deductibles)

Covered Services	What You Pay	How to Obtain Benefits
In the Doctor's Office ▪ All physicians' visits, including preventive care and well-child care ▪ Lab, X-rays, allergy tests, other diagnostic services ▪ Care for urgent problems, day or night ▪ Routine immunizations and physical examinations ▪ Surgery, casts, dressings administered in the office ▪ Care by specialists (for example, cardiologists, oncologists) ▪ Certain short-term therapies (e.g. physical, speech, occupational)	▪ You pay your $0, $100 or $1,200* deductible for each member each year. ▪ Deductible expenses for your entire family are limited to twice your individual deductible (which is your family deductible). ▪ Once an individual has met his or her individual deductible, we pay 80 percent of the allowed amount and you pay 20 percent co-insurance until you reach your individual out-of-pocket limit ($600 for the $0 and $100 deductible plans or $1,800 for the $1,200 plan). ▪ If the family meets the family deductible, we pay 80 percent co-insurance for all family members' services. ▪ After you meet your out-of-pocket limit, you pay nothing for the rest of the year. ▪ If your family reaches the family out-of-pocket limit ($1,200 for the $0 and $100 deductible plans or $3,600 for the $1,200 plan), we pay 100 percent for all family members' expenses for the rest of the calendar year.	▪ Use participating providers. If you use non-participating providers, your out-of-pocket expenses may be much higher. ▪ See prior approval program description on page 6. ▪ See next page for a description of your mental health and substance abuse benefits. ▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.
OB-GYN Office Visits ▪ Gynecological care ▪ Pre-natal and post-natal maternity care		▪ Use a participating OB/GYN provider. You may pay more out-of-pocket if you use a non-participating provider.
Inpatient Care in a Hospital ▪ Appropriate room and board accommodations ▪ All covered physicians' services, including surgery ▪ Maternity care for mother and child ▪ Laboratory, diagnostic and X-ray services ▪ Drugs and medications received *as an inpatient* ▪ Therapy services		▪ See prior approval program description on page 6. ▪ See next page for a description of your mental health and substance abuse treatment benefits.
Hospital Emergency Care Emergency room care is covered only if your symptoms are severe enough that the absence of immediate medical attention could reasonably be expected to: ▪ place your physical or mental health in serious jeopardy; or ▪ cause serious impairment to bodily functions; or ▪ cause serious dysfunction of any bodily organ or part.		▪ You may pay more out-of-pocket if you use a Non-participating provider.
Hospital Outpatient Care ▪ Outpatient surgery ▪ Lab, X-rays, EKG and other diagnostic services ▪ Certain short-term therapies (e.g. physical, speech, occupational)		▪ Use a participating provider. You may pay more out-of-pocket if you use a non-participating provider. ▪ See description of prior approval program on page 6. ▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.

*** The $1,200 deductible comprehensive plan includes a $20 co-payment for each office visit with a Primary Care Physician (provider in general practice, family practice, internal medicine, naturopathic medicine or pediatrics). Co-payments do not count toward your out-of-pocket limit.**

Covered Services	What You Pay	How to Obtain Benefits
Ambulance In or Out of Service Area ▪ Ambulance service to the nearest facility in an emergency ▪ Non-emergency transfer between facilities	▪ You pay your $0, $100 or $1,200 deductible for each member each year. ▪ Deductible expenses for your entire family are limited to twice your individual deductible (which is your family deductible). ▪ Once an individual has met his or her individual deductible, we pay 80 percent of the allowed amount and you pay 20 percent co-insurance until you reach your individual out-of-pocket limit ($600 for the $0 and $100 deductible plans or $1,800 for the $1,200 plan). ▪ If the family meets the family deductible, we pay 80 percent co-insurance for all family members' services. ▪ After you meet your out-of-pocket limit, you pay nothing for the rest of the year. ▪ If your family reaches the family out-of-pocket limit ($1,200 for the $0 and $100 deductible plans or $3,600 for the $1,200 plan), we pay 100 percent for all family members' expenses for the rest of the calendar year.	▪ Your condition must meet the criteria for an emergency medical condition in your Certificate of Coverage. ▪ A transfer to another facility is covered when necessary to meet the patient's needs, but not covered when it is the patient's or provider's preference.
Home Care ▪ Skilled nursing visits, short-term therapy delivered in your home ▪ Private duty nursing		▪ You may pay more out-of-pocket if you use a non-participating provider. ▪ We limit private duty nursing benefits to 14 hours per calendar year.
Chiropractic Care ▪ Services to treat a neuromusculoskeletal condition		▪ You must use a participating chiropractor. We do not cover services by non-participating chiropractors. ▪ You need prior approval for any visits after 12 in a calendar year.
Mental Health and Substance Abuse Treatment ▪ Inpatient care ▪ Outpatient visits		▪ You need prior approval. Call the prior approval number on the back of your ID card to initiate treatment.
Prescription Drugs ▪ Prescription drugs and antigens prescribed by a physician for FDA-approved uses ▪ Diabetic supplies including test strips, insulin and syringes	▪ $0 annual prescription drug deductible, then ▪ a $5 co-payment for generic drugs, or ▪ a $20 co-payment for Preferred Brand-name drugs, or ▪ a $45 co-payment for Non-preferred Brand-name drugs. ▪ Out-of-pocket maximums for prescription drugs are $600 per individual or $1,200 for a family.	▪ Use a network pharmacy. We do not cover prescription drugs you purchase at an out-of-network pharmacy. ▪ See page 9 for details about how to save money with the convenient mail order service. ▪ You need prior approval before you buy certain drugs. See page 9 for details about the prior approval program. ▪ Your prescription drug co-payments **do not** count toward your medical out-of-pocket limit.
Medical Equipment and Supplies ▪ Supplies and equipment that have no non-medical use	▪ $0, $100 or $1,200 deductible per member (family deductible is twice individual). 20 percent co-insurance until out-of-pocket maximum reached (see above), then you pay nothing.	▪ You may pay more out-of-pocket if you use a non-participating provider. ▪ See description of prior approval program on page 6.
Vision Exams	▪ No benefits	▪ No benefits

Grandfathered CDHP Blue $1,800 (HSA/HRA-Compatible)

Covered Services	What You Pay	How to Obtain Benefits
Preventive Care ▪ Well-child care, adult physical exams ▪ Screening mammograms and colorectal screening ▪ Excludes diagnostic services	▪ No member cost	
In the Doctor's Office ▪ All physicians' visits, including preventive care and well-child care ▪ Lab, X-rays, allergy tests, other diagnostic services ▪ Care for urgent problems, day or night ▪ Routine immunizations and physical examinations ▪ Surgery, casts, dressings administered in the office ▪ Care by specialists (for example, cardiologists, oncologists) ▪ Certain short-term therapies (e.g. physical, speech, occupational)	▪ You pay your $1,800 individual or $3,600 family deductible each year. If you have a family plan, your family must meet the family deductible before the plan pays any benefits. ▪ If the family meets the family deductible, we pay 100 percent of the allowed amount for all family members' services.	▪ Use participating providers. If you use non-participating providers, your out-of-pocket expenses may be much higher. ▪ See prior approval program description on page 76. ▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.
OB-GYN Office Visits ▪ Gynecological care ▪ Pre-natal and post-natal maternity care		▪ Use a participating OB/GYN provider. You may pay more out-of-pocket if you use a non-participating provider.
Inpatient Care in a Hospital ▪ Appropriate room and board accommodations ▪ All covered physicians' services, including surgery ▪ Maternity care for mother and child ▪ Laboratory, diagnostic and X-ray services ▪ Drugs and medications received as an inpatient ▪ Therapy services		▪ You must comply with the Precertification program requirements by calling for Preadmission or Admission Review. ▪ See Prior Approval program description on page 6. ▪ See next page for a description of your mental health and substance abuse treatment benefits.
Hospital Emergency Care Emergency room care is covered only if your symptoms are severe enough that the absence of immediate medical attention could reasonably be expected to: ▪ place your physical or mental health in serious jeopardy; or ▪ cause serious impairment to bodily functions; or ▪ cause serious dysfunction of any bodily organ or part.		▪ You may pay more out-of-pocket if you use a non-participating provider.
Hospital Outpatient Care ▪ Outpatient surgery ▪ Lab, X-rays, EKG and other diagnostic services ▪ Certain short-term therapies (e.g. physical, speech, occupational)		▪ Use a participating provider. You may pay more out-of-pocket if you use a non-participating provider. ▪ See description of Prior Approval program on page 6. ▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.

Covered Services	What You Pay	How to Obtain Benefits
Ambulance In or Out of Service Area ▪ Ambulance service to the nearest facility in an emergency ▪ Non-emergency transfer between facilities	▪ You pay your $1,800 individual or $3,600 family deductible each year. If you have a family plan, your family must meet the family deductible before the plan pays any benefits.. ▪ If the family meets the family deductible, we pay 100 percent of the allowed amount for all family members' services.	▪ Your condition must meet the criteria for an emergency medical condition in your Certificate of Coverage. ▪ A transfer to another facility is covered when necessary to meet the patient's needs, but not covered when it is the patient's or provider's preference.
Home Care ▪ Skilled nursing visits, short-term therapy delivered in your home ▪ Private duty nursing		▪ You may pay more out-of-pocket if you use a non-participating provider. ▪ We limit private duty nursing benefits to 14 hours per calendar year.
Chiropractic Care ▪ Services to treat a neuromusculoskeletal condition		▪ You must use a participating chiropractor. We do not cover services by non-participating chiropractors. ▪ You need prior approval for any visits after 12 in a calendar year.
Mental Health and Substance Abuse Treatment ▪ Inpatient care ▪ Outpatient visits		▪ You need prior approval. Call the prior approval number on the back of your ID card to initiate treatment.
Prescription Drugs ▪ Prescription drugs and antigens prescribed by a physician for FDA-approved uses ▪ Diabetic supplies including test strips, insulin and syringes	▪ Out-of-pocket maximums for prescription drugs are $1,250 per individual or $2,500 for a family. ▪ Money you spend on prescription drugs applies to your general deductible and out-of-pocket maximum as well as your prescription drug out-of-pocket maximum.	▪ Use a network pharmacy. We do not cover prescription drugs you purchase at an out-of-network pharmacy. ▪ See page 9 for details about how to save money with the convenient mail order service. ▪ You need prior approval before you buy certain drugs. See page 9 for details about the Prior Approval program.
Medical Equipment and Supplies ▪ Supplies and equipment that have no non-medical use	▪ You pay your $1,800 individual or $3,600 family deductible each year. If you have a family plan, your family must meet the family deductible before the plan pays any benefits. ▪ If the family meets the family deductible, we pay 100 percent of the allowed amount for all family members' services.	▪ You may pay more out-of-pocket if you use a non-participating provider. ▪ See description of Prior Approval program on page 6.
Vision Exams	▪ No benefits	▪ No benefits

Non-grandfathered Comprehensive Option

($1,200 Deductible)

Covered Services	What You Pay	How to Obtain Benefits
Preventive Care ▪ Well-child care, adult physical exams ▪ OB-GYN preventive visits ▪ Preventive labs and X-rays ▪ Screening mammograms and colonoscopies	▪ No member cost.	
In the Doctor's Office ▪ All physicians' visits, including preventive care and well-child care ▪ Lab, X-rays, allergy tests, other diagnostic services ▪ Care for urgent problems, day or night ▪ Routine immunizations and physical examinations ▪ Surgery, casts, dressings administered in the office ▪ Care by specialists (for example, cardiologists, oncologists) ▪ Certain short-term therapies (e.g. physical, speech, occupational)	You pay $20 for primary care office visits other than for preventive care. This co-payment applies to your out-of-pocket limit, but not to your deductible. For all other care: ▪ You pay your $1,200 deductible for each member each year. ▪ Deductible expenses for your entire family are limited to twice your individual deductible (which is your family deductible). ▪ Once an individual has met his or her individual deductible, we pay 80 percent of the allowed amount and you pay 20 percent co-insurance until you reach your individual out-of-pocket limit. ▪ If the family meets the family deductible, we pay 80 percent co-insurance for all family members' services. ▪ After you meet your out-of-pocket limit of $1,800, you pay nothing for the rest of the year. Co-payments, deductibles and co-insurance all apply to the out-of-pocket limit. ▪ If your family reaches the family out-of-pocket limit of $3,600, we pay 100 percent for all family members' expenses for the rest of the calendar year.	▪ Use participating providers. If you use non-participating providers, your out-of-pocket expenses may be much higher. ▪ See Prior Approval program description on page 6. ▪ See next page for a description of your mental health and substance abuse benefits. ▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.
OB-GYN Office Visits ▪ Gynecological care ▪ Pre-natal and post-natal maternity care		▪ Use a participating OB/GYN provider. You may pay more out-of-pocket if you use a non-participating provider.
Inpatient Care in a Hospital ▪ Appropriate room and board accommodations ▪ All covered physicians' services, including surgery ▪ Maternity care for mother and child ▪ Laboratory, diagnostic and X-ray services ▪ Drugs and medications received ***as an inpatient*** ▪ Therapy services		▪ You must comply with the Precertification program requirements by calling for Preadmission or Admission Review. ▪ See Prior Approval program description on page 6. ▪ See next page for a description of your mental health and substance abuse treatment benefits.
Hospital Emergency Care Emergency room care is covered only if your symptoms are severe enough that the absence of immediate medical attention could reasonably be expected to: ▪ place your physical or mental health in serious jeopardy; or ▪ cause serious impairment to bodily functions; or ▪ cause serious dysfunction of any bodily organ or part.		▪ You may pay more out-of-pocket if you use a non-participating provider.
Hospital Outpatient Care ▪ Outpatient surgery ▪ Lab, X-rays, EKG and other diagnostic services ▪ Certain short-term therapies (e.g. physical, speech, occupational)		▪ Use a participating provider. You may pay more out-of-pocket if you use a non-participating provider. ▪ See description of Prior Approval program on page 6. ▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.

Covered Services	What You Pay	How to Obtain Benefits
Ambulance In or Out of Service Area ▪ Ambulance service to the nearest facility in an emergency ▪ Non-emergency transfer between facilities	▪ You pay your $1,200 deductible for each member each year. ▪ Deductible expenses for your entire family are limited to twice your individual deductible (which is your family deductible). ▪ Once an individual has met his or her individual deductible, we pay 80 percent of the Allowed amount and you pay 20 percent co-insurance until you reach your individual out-of-pocket limit. ▪ If the family meets the family deductible, we pay 80 percent co-insurance for all family members' services. ▪ After you meet your out-of-pocket limit of $1,800, you pay nothing for the rest of the year. ▪ If your family reaches the family out-of-pocket limit of $3,600, we pay 100 percent for all family members' expenses for the rest of the calendar year.	▪ Your condition must meet the criteria for an emergency medical condition in your Certificate of Coverage. ▪ A transfer to another facility is covered when necessary to meet the patient's needs, but not covered when it is the patient's or provider's preference.
Home Care ▪ Skilled nursing visits, short-term therapy delivered in your home ▪ Private duty nursing		▪ You may pay more out-of-pocket if you use a non-participating provider. ▪ We limit private duty nursing benefits to 14 hours per calendar year.
Chiropractic Care ▪ Services to treat a neuromusculoskeletal condition		▪ You must use a participating chiropractor. We do not cover services by non-participating chiropractors. ▪ You need prior approval for any visits after 12 in a calendar year.
Mental Health and Substance Abuse Treatment ▪ Inpatient care ▪ Outpatient visits		▪ You need prior approval. Call the prior approval number on the back of your ID card to initiate treatment.
Prescription Drugs ▪ Prescription drugs and antigens prescribed by a physician for FDA-approved uses ▪ Diabetic supplies including test strips, insulin and syringes	▪ $0 annual prescription drug deductible, then ▪ a $5 co-payment for generic drugs, or ▪ a $20 co-payment for Preferred Brand-name drugs, or ▪ a $45 co-payment for Non-preferred Brand-name drugs. ▪ Out-of-pocket maximums for prescription drugs are $600 per individual or $1,200 for a family.	▪ Use a network pharmacy. We do not cover prescription drugs you purchase at an out-of-network pharmacy. ▪ See page 9 for details about how to save money with the convenient mail order service. ▪ You need prior approval before you buy certain drugs. See page 9 for details about the prior approval program.
Medical Equipment and Supplies ▪ Supplies and equipment that have no non-medical use	▪ $0, $100 or $1,200 deductible per member (family deductible is twice individual). 20 percent co-insurance until out-of-pocket maximum reached (see above), then you pay nothing.	▪ You may pay more out-of-pocket if you use a non-participating provider. ▪ See description of our prior approval program on page 6.
Vision Exams	▪ No benefits	▪ No benefits

Non-Grandfathered CDHP Blue $1,800 (HSA/HRA-Compatible)

Covered Services	What You Pay	How to Obtain Benefits
Preventive Care ▪ Well-child care, adult physical exams ▪ OB-GYN preventive visits ▪ Preventive labs and X-rays ▪ Screening mammograms and colonoscopies	▪ No member cost.	
In the Doctor's Office ▪ All physicians' visits, including preventive care and well-child care ▪ Lab, X-rays, allergy tests, other diagnostic services ▪ Care for urgent problems, day or night ▪ Routine immunizations and physical examinations ▪ Surgery, casts, dressings administered in the office ▪ Care by specialists (for example, cardiologists, oncologists) ▪ Certain short-term therapies (e.g. physical, speech, occupational)	▪ You pay your $1,800 deductible for each member each year. ▪ Deductible expenses for your entire family are limited to twice your individual deductible (which is your family deductible). ▪ If the family meets the family deductible, we pay 100 percent of the allowed amount for all family members' services.	▪ Use participating providers. If you use non-participating providers, your out-of-pocket expenses may be much higher. ▪ See Prior Approval program description on page 6. ▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.
OB-GYN Office Visits ▪ Gynecological care ▪ Pre-natal and post-natal maternity care		▪ Use a participating OB/GYN provider. You may pay more out-of-pocket if you use a non-participating provider.
Inpatient Care in a Hospital ▪ Appropriate room and board accommodations ▪ All covered physicians' services, including surgery ▪ Maternity care for mother and child ▪ Laboratory, diagnostic and X-ray services ▪ Drugs and medications received as an inpatient ▪ Therapy services		▪ You must comply with the Precertification program requirements by calling for Preadmission or Admission Review. ▪ See Prior Approval program description on page 6. ▪ See next page for a description of your mental health and substance abuse treatment benefits.
Hospital Emergency Care Emergency room care is covered only if your symptoms are severe enough that the absence of immediate medical attention could reasonably be expected to: ▪ place your physical or mental health in serious jeopardy; or ▪ cause serious impairment to bodily functions; or ▪ cause serious dysfunction of any bodily organ or part.		▪ You may pay more out-of-pocket if you use a non-participating provider.
Hospital Outpatient Care ▪ Outpatient surgery ▪ Lab, X-rays, EKG and other diagnostic services ▪ Certain short-term therapies (e.g. physical, speech, occupational)		▪ Use a participating provider. You may pay more out-of-pocket if you use a non-participating provider. ▪ See description of Prior Approval program on page 6. ▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.

Covered Services	What You Pay	How to Obtain Benefits
Ambulance In or Out of Service Area ▪ Ambulance service to the nearest facility in an emergency ▪ Non-emergency transfer between facilities	▪ You pay your $1,800 deductible for each member each year. ▪ Deductible expenses for your entire family are limited to twice your individual deductible (which is your family deductible). ▪ If the family meets the family deductible, we pay 100 percent of the allowed amount for all family members' services.	▪ Your condition must meet the criteria for an emergency medical condition in your Certificate of Coverage. ▪ A transfer to another facility is covered when necessary to meet the patient's needs, but not covered when it is the patient's or provider's preference.
Home Care ▪ Skilled nursing visits, short-term therapy delivered in your home ▪ Private duty nursing		▪ You may pay more out-of-pocket if you use a non-participating provider. ▪ We limit private duty nursing benefits to 14 hours per calendar year.
Chiropractic Care ▪ Services to treat a neuromusculoskeletal condition		▪ You must use a participating chiropractor. We do not cover services by non-participating chiropractors. ▪ You need prior approval for any visits after 12 in a calendar year.
Mental Health and Substance Abuse Treatment ▪ Inpatient care ▪ Outpatient visits		▪ You need prior approval. Call the prior approval number on the back of your ID card to initiate treatment.
Prescription Drugs ▪ Prescription drugs and antigens prescribed by a physician for FDA-approved uses ▪ Diabetic supplies including test strips, insulin and syringes	▪ Out-of-pocket maximums for prescription drugs are $1,250 per individual or $2,500 for a family.	▪ Use a network pharmacy. We do not cover prescription drugs you purchase at an out-of-network pharmacy. ▪ See page 9 for details about how to save money with the convenient mail order service. ▪ You need prior approval before you buy certain drugs. See page 9 for details about the Prior Approval program.
Medical Equipment and Supplies ▪ Supplies and equipment that have no non-medical use	▪ You pay your $1,800 deductible for each member each year. ▪ Deductible expenses for your entire family are limited to twice your individual deductible (which is your family deductible). ▪ If the family meets the family deductible, we pay 100 percent of the allowed amount for all family members' services.	▪ You may pay more out-of-pocket if you use a non-participating provider. ▪ See description of Prior Approval program on page 76.
Vision Exams	▪ No benefits	▪ No benefits

Comparison of Grandfathered Plans for Active Employees

Selected Service	JY Plan	Dual Option Vermont Health Partnership	Dual Option $300 Comprehensive Plan
Primary Care Physician	You need not select a Primary Care Physician.	You select a Primary Care Physician upon enrollment.	You need not select a Primary Care Physician.
Office Visits	We pay all but your $20 office visit co-payment.	You pay: ▪ $15 co-payment for visits with your Primary Care Physician ▪ $25 co-payment for visits with network specialty providers We pay the rest. Standard benefits are available for some out-of-network visits.	You pay your $300 individual or $600 family deductible, then 20 percent until you reach your $600 individual or $1,200 family out-of-pocket limit.
Prescription Drugs	You pay: No deductible ▪ $5 co-payment for each generic prescription ▪ $20 co-payment for each prescription on our Preferred Brand-name Drug List ▪ $45 co-payment for each Non-preferred prescription ▪ Out-of-pocket maximums for prescription drugs are $600 per individual or $1,200 for a family.		
Hospital Inpatient and Outpatient	We pay 100 percent of the allowed amount.	We pay 100 percent of the allowed amount. Standard benefits are available for some out-of-network visits.	You pay your deductible, then 20 percent until you reach your $600 individual or $1,200 family out-of-pocket limit.
Emergency Care	You pay a $20 co-payment for the ER physician. We pay 100 percent of the allowed amount.	We pay 100 percent of the allowed price.	
Inpatient Mental Health Services**	Covered in full. You may need to contact BCBSVT for prior approval to initiate mental health care.	We pay 100 percent of the allowed amount. You must contact our mental health network to initiate mental health care.	You pay your deductible, then 20 percent until you reach your $600 individual or $1,200 family out-of-pocket limit. You may need to contact BCBSVT for prior approval to initiate mental health care.
Outpatient Mental Health Services**	Same as office visits (above). You may need to contact our mental health network to initiate mental health care.	You pay a $25 co-payment for each visit. We cover the rest. You must contact BCBSVT for prior approval to initiate mental health care..	
Chiropractic Services	You pay a $20 co-payment. You must use participating providers and get prior approval for any visits after 12 in a calendar year.	You pay a $25 co-payment for each visit. You must use network providers and get prior approval for any visits after 12 in a calendar year. No Standard benefits are available.	You pay your deductible, then 20 percent until you reach your $600 individual or $1,200 family out-of-pocket limit. You must use participating providers and get prior approval for any visits after 12 in a calendar year.
Lifetime Maximum (all services)	None	None	None

	$0 or $100 Comprehensive Plans	Comprehensive Plus $1,200 Deductible	CDHP Blue $1,800 Deductible
	You pay your deductible (limited to $200 per family for the $100 plan), then 20 percent until you reach your $600 individual or $1,200 family out-of-pocket limit.	You pay $20 for primary care office visits. For all other visits, you pay your deductible, then 20 percent until you reach your $1,800 individual or $3,600 family out-of-pocket limit.	No member cost for certain preventive care. For all other visits, you pay your $1,800 or $3,600 deductible each year and we cover the rest of your care at 100 percent of the allowed amount.
			You pay your $1,800 or $3,600 deductible each year and we cover the rest of your care at 100 percent of the allowed amount.
	You pay your deductible (limited to $200 per family for the $100 plan), then 20 percent until you reach your $600 individual or $1,200 family out-of-pocket limit.	You pay your deductible, then 20 percent until you reach your $1,800 individual or $3,600 family out-of-pocket limit.	You pay your $1,800 or $3,600 deductible each year and we cover the rest of your care at 100 percent of the allowed amount.
	You pay your deductible (limited to $200 per family for the $100 plan), then 20 percent until you reach your $600 individual or $1,200 family out-of-pocket limit. You may need to contact BCBSVT for prior approval to initiate mental health care.	You pay your deductible, then 20 percent until you reach your $1,800 individual or $3,600 family out-of-pocket limit. You may need to contact BCBSVT for prior approval to initiate mental health care.	You pay your $1,800 or $3,600 deductible each year and we cover the rest of your care at 100 percent of the allowed amount. You may need to contact BCBSVT for prior approval to initiate mental health care.
	You pay your deductible (limited to $200 per family for the $100 plan), then 20 percent until you reach your $600 individual or $1,200 family out-of-pocket limit. You must use participating providers and get prior approval for any visits after 12 in a calendar year.	You pay your deductible, then 20 percent until you reach your $1,800 individual or $3,600 family out-of-pocket limit. You must use participating providers and get prior approval for any visits after 12 in a calendar year.	You pay your $1,800 or $3,600 deductible each year and we cover the rest of your care at 100 percent of the allowed amount. You must use participating providers and get prior approval for any visits after 12 in a calendar year.
	None	None	None

Comparison of Non-Grandfathered Plans for Active Employees

Selected Service	Comprehensive Plus $1,200 Deductible	CDHP Blue
Primary Care Physician	You need not select a Primary Care Physician.	
Preventive Care	No member cost for all care determined by the United State Preventive Services Task Force as preventive care. Could include well-child care, adult physical exams, OB-GYN preventive visits, preventive labs and X-rays, screening mammograms and colonoscopies.	No member cost for all care determined by the United State Preventive Services Task Force as preventive care. Could include well-child care, adult physical exams, OB-GYN preventive visits, preventive labs and X-rays, screening mammograms and colonoscopies.
Other Office Visits	You pay $20 for primary care office visits other than preventive care. For all other visits, you pay your deductible, then 20 percent until you reach your $1,800 individual or $3,600 family out-of-pocket limit. Co-payments apply to the out-of-pocket limit.	For all other visits, you pay your $1,800 or $3,600 deductible each year and we cover the rest of your care at 100 percent of the allowed amount.
Prescription Drugs	You pay: ▪ $5 co-payment for each generic prescription ▪ $20 co-payment for each prescription on our Preferred Brand-name Drug List ▪ $45 co-payment for each Non-preferred prescription ▪ Out-of-pocket maximums for prescription drugs are $600 per individual or $1,200 for a family	▪ Out-of-pocket maximums for prescription drugs are $600 per individual or $1,200 for a family
Hospital Inpatient and Outpatient **Emergency Room**	You pay your deductible, then 20 percent until you reach your $1,800 individual or $3,600 family out-of-pocket limit.	You pay your $1,800 deductible each year and we cover the rest of your care at 100 percent of the allowed amount.
Inpatient Mental Health Services** **Outpatient Mental Health Services****	You pay your deductible, then 20 percent until you reach your $1,800 individual or $3,600 family out-of-pocket limit. You may need to contact BCBSVT for prior approval to initiate mental health care.	You pay your $1,800 deductible each year and we cover the rest of your care at 100 percent of the allowed amount. You may need to contact BCBSVT for prior approval to initiate mental health care.
Chiropractic Services	You pay your deductible, then 20 percent until you reach your $1,800 individual or $3,600 family out-of-pocket limit. You must use participating providers and get prior approval for any visits after 12 in a calendar year.	You pay your $1,800 deductible each year and we cover the rest of your care at 100 percent of the allowed amount. You must use Participating providers and get prior approval for any visits after 12 in a calendar year.
Lifetime Maximum (all services)	None	None

On the Web

My Blue Health: a closer look at exercise tools

You can create your own online wellness program with My Blue Health, Blue Cross and Blue Shield of Vermont's member wellness portal. It allows you to create personalized programs to track your diet and exercise and improve your overall health.

Visit **www.bcbsvt.com/member** to take advantage of these free tools. You can even access the wellness center through your mobile device, making it more convenient to track progress toward your health and wellness goals when you're on the go.

Our secure member site

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

- check claims status
- look up your health plan benefits
- use secure e-mail to ask questions and hear back within 24 hours
- use Healthcare Advisor to compare cost and quality data on a variety of providers, services and supplies
- order ID cards
- file a change of address

To gain entry to the member site, visit **www.bcbsvt.com/member** and click on Member Login. You will need your member identification card to register. You must enter your information in a specific format. You will enter your ID number without the three-letter prefix and your two-digit member number. The member resource center includes a graphic that will show you where to find these numbers on your ID card.

"Find a Doctor" on the BCBSVT Website

The most up-to-date provider information is available at **www.bcbsvt.com**. Click on the "Find a Doctor" Quick Link for a choice of seven different types of provider searches. You can find a local doctor, or one outside of Vermont if you're traveling. All tools are easy to use and guide you step by step through your search.

You can also go to **www.bluecares.com** to locate providers nationwide. See page 13 for more information on our BlueCard program, a national program that enables members of one Blue plan to obtain health care services while traveling or living in another Blue plan's service area.

Our full provider directories (like those we print on paper) are also available online as PDF files that you may download. Please note, however, that those directories are updated far less frequently than our Find a Doctor online database, which is updated nightly.

If you have questions about finding a doctor or would like help using the search tool, please call our member service representatives at (800) 247-2583 from 7 a.m. to 6 p.m., Monday to Friday.

www.bcbsvt.com/FindaDoctor

Notice of privacy practices

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 of your medical and/or dental insurance coverage with the Vermont Education Health Initiative ("VEHI") and/or your participating in VEHI's wellness programs. Please read it carefully. This notice refers to VEHI by using the terms "us," "we" or "our."

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

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

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

TO PLAN SPONSORS. Plan sponsors are employers or other organizations that sponsor a group health plan. We may disclose your protected health information to the plan sponsor of your group health plan. For example:

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

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

FOR DISTRIBUTION OF HEALTH-RELATED BENEFITS AND SERVICES. We may use or disclose your protected health information to provide you with information on health-related benefits and services that may interest you.

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

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

IN CONNECTION WITH PUBLIC HEALTH ACTIVITIES. We may disclose your protected health information to public health agencies for public health activities that are permitted or required by law, such as to:

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

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

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

IN THE EVENT OF A SERIOUS THREAT TO HEALTH OR SAFETY. We may, consistent with applicable law and ethical standards of conduct, disclose your protected health information if we, in good faith, believe that disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

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

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

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

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

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

AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

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

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

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

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

Notice of privacy practices (cont'd)

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

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

RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION. You have the right to inspect and copy your protected health information contained in a "designated record set," other than psychotherapy notes and certain other information. Generally, a designated record set contains enrollment, payment, claims adjudication and case or medical management records we may have about you, as well as other records that we use to make decisions about your health care benefits. A request to inspect and copy records containing your PHI must be made in writing to our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602 or by fax at (802) 229-1446. If you request a copy of your PHI, we may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

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

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

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

The request for an accounting of disclosures must be made in writing to our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602 or by fax at (802) 229-1446. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests in a 12-month period may be subject to a reasonable cost-based fee. We will inform you in advance of the fee, if applicable.

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

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

APPOINTMENT REMINDERS AND FUNDRAISING

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

OUR DUTIES WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

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

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

POTENTIAL IMPACT OF STATE LAW

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

CONTACT PERSON

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

EFFECTIVE DATE

This Notice is effective September 1, 2013.

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.

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Contact BCBSVT or VEHI

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

Mail

Blue Cross and Blue Shield of Vermont

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

Vermont Education Health Initiative

52 Pike Drive
Berlin, VT 05602

Phone

Customer Service	(800) 247-2583
Vermont-National Education Association	(802) 223-6375
Vermont School Boards Insurance Trust	(802) 223-5040
24-Hour Nurse Hotline	(866) 612-0285
Pharmacy Network	(877) 493-1949
Case management/prior approval	(800) 922-8778

Websites

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

Vermont Education Health Initiative:
www.vehi.org

Pharmacy Network:
www.express-scripts.com

In Person

Blue Cross and Blue Shield of Vermont

Berlin Office
445 Industrial Lane (off Airport Road)
Berlin, VT 05602

VEHI's health benefit plans are administered by:

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

P.O. Box 186
Montpelier, VT 05601-0186
Phone: (800) 247-2583

www.bcbsvt.com

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