Benefits of the

Vermont Education Health Initiative for Retirees

VEHI's health benefit plans are administered by:

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 condition management, access to a 24-hour nurse hotline and an expansive health information website
- Customer 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 VEHI PATH and BCBSVT, featuring online tools, face-to-face sessions and much more

About this booklet

This booklet contains information about health benefit plans for retirees. 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 view 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****.*

What is VEHI?

The Vermont Education Health Initiative (VEHI) is a large, nonprofit 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

Coverage Description 4
Our Prior Approval Program 6
Our Pharmacy Programs 8
Blue HealthSolutions® 10
Wellness Programs 11
Membership Information 12
The BlueCard® Program 14
Provider Network 14
FAQs 15
Benefit Summaries 18
BCBSVT's Website Tool 31
Find a Doctor on the BCBSVT Website 31

VEHI Coverage

Coverage for retirees

Coverage differs depending on whether you are eligible for Medicare. (Medicare acts as the primary payer, when available.) If you have two-person coverage, the person who becomes eligible for Medicare first should change his or her BCBSVT coverage to supplement Medicare. Coverage for the second person will change only when that individual becomes eligible for Medicare also.

- **Coverage for retirees without Medicare**
  - Vermont Health Partnership® Plan (page 18)
  - Comprehensive Plan with $300 Deductible (page 20)
  - JY Plan (page 22)
  - Prescription drug coverage managed through BCBSVT (pages 8 and 9)
- **Coverage for retirees with Medicare**
  - JY Carve-out Plan (page 26)
  - Comprehensive Carve-out Plan with $300 Deductible (page 28)
  - Vermont Blue 65℠ (Medi-Comp C) (page 30)
  - Prescription drug coverage managed through Blue MedicareRx℠ (PDP, BCBSVT's Part D vendor (pages 8 and 9)

Please note that all plans are "grandfathered" with respect to the Affordable Care Act. This status could change in the future.

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 provider 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:

- 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 must use network providers to receive benefits. Your coverage may require your physician to get approval from us before using certain medications or services.

General policy exclusions

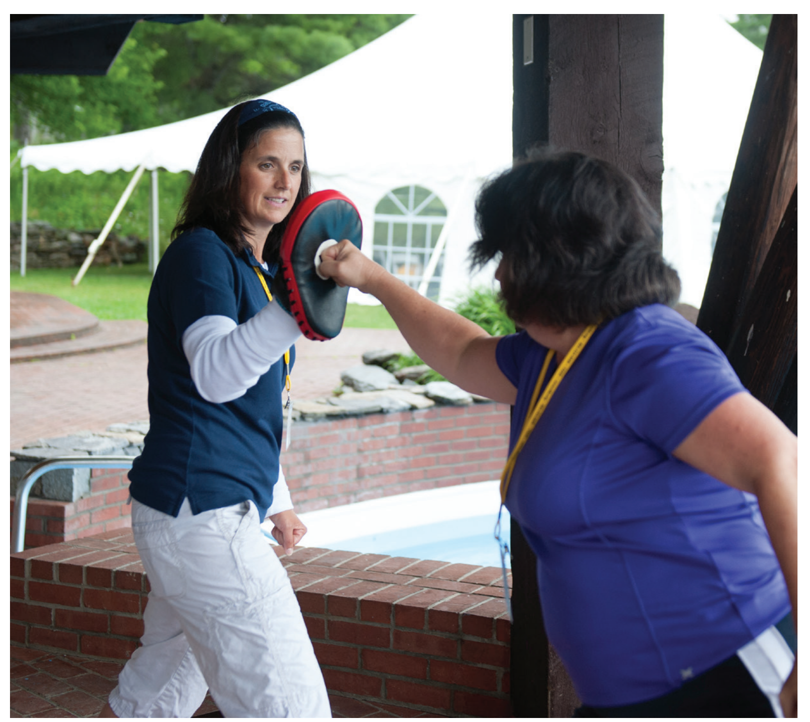
You can be confident that your health plan covers a broad array of necessary services and supplies as described in this booklet. The following points highlight some of the services that your health plan does not cover:

- 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/member/contract-documents** and navigate to a current certificate. Once enrolled, you will have access to your specific Certificate of Coverage on our online Member Resource Center, which details all General Exclusions. (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/privacypractices.** 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/priorapproval**.

Please call the customer 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 customer service department at (800) 247-2583.

Type of Procedure	What Requires Prior Approval
Ambulance	Non-emergency ambulance transport, including air or water transport;
Anesthesia	Anesthesia for colonoscopy or endoscopy
Autism	Treatment of autism spectrum disorder
Capsule Endoscopy	All services
Chemodenervation	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)	Continuous positive airway pressure/bilevel positive airway pressure (CPAP/BIPAP) machines, continuous passive motion (CPM) equipment, hospital-grade electric breast pumps (other than those provided through Better Beginnings®).
Electroconvulsive therapy	All services
Gender reassignment	Services to treat gender dysphoria
Genetic Testing	Most tests—those with Health Care Procedure Coding System (HCPCS) Codes between S3800 and S3890
Habilitation services	All services
Hyperbaric Oxygen Therapy	All services
Medical Nutrition for Inherited Metabolic Disease	Medical supplies and pumps, enteral formulae and parenteral nutrition
New Medical Procedures	New procedures still considered investigational or experimental
Non-network services	All non-network services if you have a managed care plan
Out-of-state Facility Care	All inpatient and partial inpatient care
Percutaneous radiofrequency ablation of liver	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
Psychological testing	All services
Radiology Services	All services. Examples include CT, MRI, MRA, MRS, PET echocardiogram and nuclear cardiology..
Rehabilitation	Skilled nursing facility care, inpatient rehabilitation treatment for medical conditions, intensive outpatient services or residential treatment for mental health and substance abuse conditions
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
Uvulopalatopharyngoplasty (UPPP)/somnoplasty	All services

Prescription Drug Plan

If you are eligible for Medicare Part A and/or Part B and your plan includes prescription drug benefits, you will get your prescription drugs through the* ***Blue Medicare Rx℠ prescription drug plan (PDP)****. Your coverage will include Medicare Part D benefits supplemented with coverage provided by VEHI.*

We administer this plan through a joint enterprise with three other New England Blue plans. You will use the Blue MedicareRx network of pharmacies here in Vermont and nationwide. Present your Blue Medicare Rx ID card at a network pharmacy and the pharmacist will file a claim for you. (Please note that your Blue Medicare Rx card is separate from the ID card you use for other care.)

Almost all Vermont pharmacies and a large percentage of pharmacies nationwide currently belong to the Blue Medicare Rx network. Most major chains (e.g. RiteAid, Kinney, etc.) participate. Visit ***http://Groups.RxMedicarePlans.com*** *for a list of network pharmacies. Or call Blue MedicareRx customer service toll-free at (855) 893-8538, 24 hours a day, seven days a week. Prospective members who are TTY/TDD users should call (866) 552-6288. Current members who are TTY/TDD members should call (866) 236-1069.*

Your out-of-pocket costs for Blue Medicare Rx are the same as those in the base VEHI BCBSVT plans.

If you are not eligible for Medicare Part A or B, you will continue to get your prescription drug benefits directly through Blue Cross and Blue Shield of Vermont's pharmacy network (administered by Express Scripts).

The sections that follow apply to both Blue Medicare Rx and coverage directly through BCBSVT.

Three-tier drug program

Prescription drug prices are a contributing cause in increasing health care costs and insurance premiums. One way to reduce medication costs substantially is to use generic drugs whenever possible. Generics are less expensive than brand-name medications and are just as medically effective. 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 set the generic co-payment at only $5.

*Please note that Vermont Blue 65 does not include prescription drug benefits. If you have that plan, you should consider buying a Part D plan directly through BCBSVT.

Your benefit is a $0 deductible, then:

- $5 co-payment for generic drugs
- $20 for brand-name drugs on the Caremark formulary (Preferred Brand Drugs)
- $45 for drugs not on the Caremark formulary (Non-Preferred Brand Drugs)

The formulary 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 formulary would be appropriate for you. These drugs can often meet patient needs at a lower cost. You can get a copy of the formulary (or Preferred Brand-name Drug List) online or by phone. Please see the contact information at the end of this section.

Convenient refills and savings with our mail service pharmacy program

Whether you are a Blue MedicareRx member or you still get drugs through Express Scripts, mail service (or home delivery) may be a less expensive, more convenient way for you to buy prescriptions you use on an ongoing basis. If you use mail service, you can get a 90-day supply of a drug for just two co-payments (rather than three). To begin using mail service for your maintenance drug, visit the website or call a customer service representative to get a mail service form. Then send our mail service pharmacy your doctor's prescription, an order form and your co-payment amount.

You may request refills online or by phone. See the contact information for your plan below.

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

Prior approval

Our prior approval list changes periodically. Prior approval is required for drugs that have been on the market less than 12 months, medications without National Drug Code numbers and the following types of drugs:

- 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

You can get an entire list online or by phone. Please see the contact information below.

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. You can find the most current list of drugs on which we place quantity limits online (see contact information below). 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®)

You can get a current list of drugs that require step therapy and find out about procedures to follow to proceed with review online or by phone. Please see the contact information below.

Contact Information

Blue MedicareRx

Web: http://Groups.RxMedicarePlans.com

Phone: (855) 893-8538, 24 hours a day, seven days a week.

TTY/TDD (prospective members): (866) 552-6288.

TTY/TDD (current members): (866) 236-1069.

Express Scripts

Web: www.bcbsvt.com/rxcenter

Phone: (800) 310-5249

Better care through Blue HealthSolutions℠

Blue Health Solutions is our suite of customized health and wellness programs and solutions designed to help you achieve and maintain optimal health at every stage of life. This program, in addition to your provider's treatment plan, will support you so you get the right care and screenings. That's why you may receive a call from one of our nurses or social workers to help provide you an appropriate level of support.

If you receive a call or choose to call us about one of our programs, please know that your protected health information is held strictly confidential. Blue Health Solutions programs are voluntary and available at no additional cost to you. Even though we may consider you eligible and enrolled in a program, you can always opt out at any time.

Staying healthy

Fitness and health events

Staying fit and healthy is an important part of preventing illnesses. It's not always easy to maintain a healthy lifestyle. That's why Blue Cross and Blue Shield of Vermont holds many signature events each year that help Vermonters get out and get active. They range from walking challenges at Vermont worksites to "Hike, Bike & Paddle" events at Vermont lakes and ponds to "Family Days" and "Snow Days" at some of our state's most beautiful venues.

While Blue Cross and Blue Shield of Vermont aims to improve your 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.

Blue Extras℠

Our Blue Extras health and wellness program 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/blueextras**.

My Blue Health

By using the tools on the My Blue Health and Wellness Center℠ (**https://mybluehealth.bcbsvt.com**) link from 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.

Healthwise Knowledgebase®

Log on to our secure Member Resource Center at **www.bcbsvt.com** to use our online tools, including the Healthwise Knowledgebase, which contains thousands of pages of information about health topics, or the Health Advisor, which helps you compare price and quality of care from various providers.

Better Beginnings®

Expecting a new addition to the family? Our plans offer the Better Beginnings maternal health program to help you provide the healthiest, happiest start for your baby. Better Beginnings offers you pregnancy and post-delivery support.

When you enroll in the program, one of our Better Beginnings nurses will work with you and your health care provider to promote healthy outcomes for you and your baby. The Better Beginnings program has played an important role in lowering our state's premature birth rate. A premature birth is not only dangerous for your baby, but also for you as the mother. Your Better Beginnings nurse will work directly with you to identify any risks that could lead to complications with your pregnancy and help you to decrease those risks.

The program offers a choice of several different benefit options. If you participate before your 34th week of pregnancy we will offer you an enhanced benefit. A sample of benefits provided includes but is not limited to:

- Homemaker services to clean your house
- Reimbursements towards a car seat or fitness classes
- Reimbursements towards birthing classes
- Your choice of a book from our specially selected Better Beginnings book list

Your Better Beginnings nurse will review the program benefits with you and because every pregnancy is different, we tailor the program to meet your individual needs.

Getting better

24-hour nurse line

Whether you need a first-aid tip, advice about whether your concern needs medical attention or have a chronic condition, 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.

Case management

If you suffer a catastrophic health event or have a complex condition, Blue Cross and Blue Shield of Vermont has a case management program to help you and your provder manage your care and appropriately use the benefits you receive from your health plan. While your provider is your primary resource for medical questions and concerns, your case manager is your dedicated advocate at the health plan who will coordinate your benefits, while finding programs, services and support systems that can help you and your family.

Blue Cross and Blue Shield of Vermont has a staff of licensed professional nurses and social workers on hand to help you. In addition to assessing your health status and current needs, our case managers desire to know you on a more personal level to better support you. Your case manager will help you decide your personal health goals, take action on those goals, and coordinate with your health care providers to help you reach your goals.

Your case manager will also teach you about how to better manage your health after completion of the program so you will be well equipped to handle any changes to your health. Your case manager may provide

educational material about your condition and treatment plan and coordinate resources so that you get timely and affordable care and use your benefits in the best way.

Other benefits of case management include assisting to find alternative funding and transportation if necessary and available.

If you have any questions concerning coordination of care, or if you are interested in learning more about our case management program, please call us at (800) 922-8778 and choose option 1.

Chronic condition management

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

We offer help for a variety of conditions including:

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

A nurse may reach out to you and touch base about your condition. They want to be sure that you're getting the best care and screening available and help you stay on track with your provider's treatment plan. Please know that our conversations with chronic condition management participants are strictly confidential and that participation in the program is always voluntary.

Rare condition management

If you have a rare condition, such as Crohn's disease, hemophilia or epilepsy, we can offer you specialized help when local support may be hard to find. We can connect you to a nurse who has expert knowledge of your rare condition. This one-on-one help can help you improve your total health and manage multiple and complex conditions.

Retirees Wellness Program

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

- ✓ Create a VEHI PATH account or access the one you've already set up. (**www.tomypath.com**) *If you have recently retired, please contact our office to have your existing account moved to the retiree group.*
- ✓ Take advantage of our many services and activities.
- ✓ Earn PATHpoints and incentive rewards.
- ✓ Share newfound skills and information with your household members.
- ✓ Access Blue Health Solutions, the BCBSVT website of online tools.
- ✓ Participate in BCBSVT winter and summer outdoor events

PATH Adventures —These themed annual 10-week virtual adventures focus on fitness, healthy eating and stress management. Participants report increasing their physical activity, feeling healthier all around and losing weight

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

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

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

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

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

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

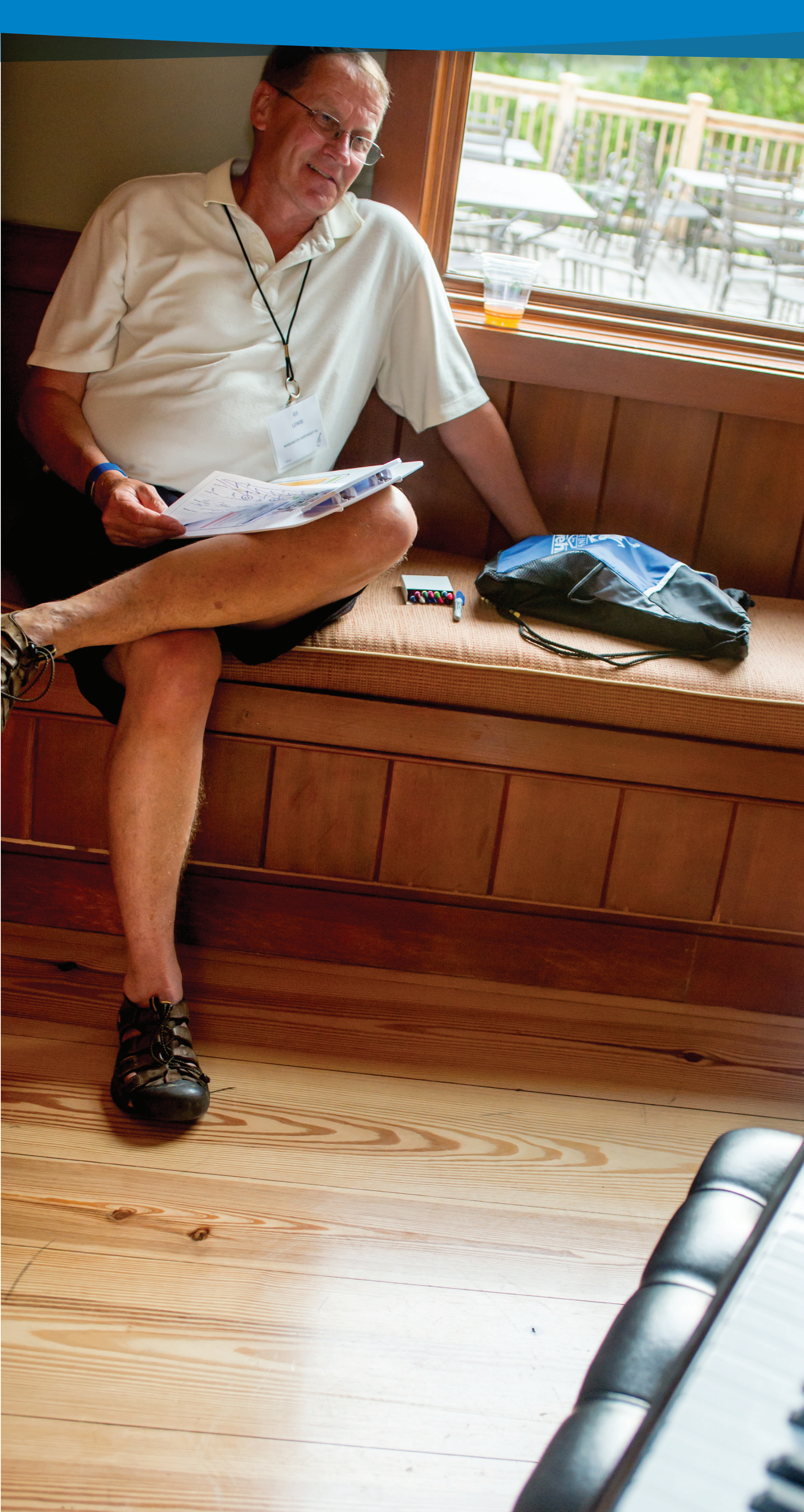
Sizzlin' Summer Challenge —This weekly summer challenge is all about taking photos of some light hearted family health goals, sharing them on our Facebook page and qualifying for the grand prize. It's stress free and fun for all members of your household.

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

Membership Information

Open enrollment

VEHI provides retirees with two open enrollment periods, January 1 and July 1. You may add dependents on either of those dates. Retirees may switch medical plans once per year, either on January 1 or July 1. The new coverage will be effective the first of the month following receipt of your application.



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 60 days.

If you do not have a family membership, we cover your child for 60 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 60 days. If we receive your request within the 60 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.

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"

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

You must request coverage no later than 60 days after losing coverage from Medicaid or Dr. Dynasaur. You may choose either the date coverage ends or the first of the month following 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.

Choosing Providers

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. Choose BCBSVT Network Providers from the drop-down box marked "Networks."

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.

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 90 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.

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 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 plan 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 8-9 for details.

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

The Vermont Health Partnership is a point-of-service (POS) plan. In this type of plan, your primary care provider (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 provider, 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 Plan J at first, can I later change my mind and move into the $300 Comprehensive 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 "Open Enrollment" on page 12). You must give written notice to BCBSVT at least 30 days prior to the date you will be changing options. Contact a retirement specialist at Vermont State Teachers' Retirement System (VSTRS) for the forms you need. Retirees with Medicare cannot enroll in the Vermont Health Partnership.

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 providers (PCPs). Some advanced practice registered nurses (APRNs) 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 providers participating in the VHP network?

Most are. In order to join the network, a primary care provider must apply and be credentialed by BCBSVT. Presently, 85 percent of in-state BCBSVT primary care providers 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 providers in the "Find-a-Doctor" section of our website at **www.bcbsvt.com/findadoctor**.

8. What if my present primary care provider 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 providers (PCPs). Second, you could consider picking a different PCP who is in the network. Remember, while you do not need a referral from your PCP for specialty care, you do need to use your PCP for your primary care needs. Finally, you may consider another health plan option. The list of PCPs continues to grow, so you should regularly consult the most current listing. Call customer service at (800) 247-2583 to get a current list or log on to our website at **www.bcbsvt.com/findadoctor**.

9. If I select the VHP plan, can I designate a different primary care provider (PCP) for each member of my family?

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

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

Although the *Directory of primary care providers* lists many 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 provider who is accepting new patients.

11. How often can I change my primary care provider under VHP?

We encourage you to develop a long-term relationship with your primary care provider (PCP). 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, through our member resource center online, by phone or in writing, by the 15th of the month in order to properly notify your new PCP 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 for in-state services?

It is not necessary for your primary care provider (PCP) to submit a written referral to BCBSVT for in-state services. But we encourage you to contact your PCP 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 provider 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 nonemergency 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 nonemergency 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 nonemergency 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 18 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 then take advantage of rates negotiated by our sister plans.

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

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

17. If I have Medicare Parts A and B, and a Carve-out plan through BCBSVT, do I need another supplemental plan?

Another supplemental plan is not necessary. Your Carve-out plan works with Medicare Parts A and B to cover most necessary medical expenses, including prescriptions.

18. If I have Medicare Parts A and B and a Vermont Blue 65 (Medi-Comp C) policy through BCBSVT, do I need any other coverage?

The only other coverage you may need to consider is prescription drug coverage. Medicare Parts A and B and the Vermont Blue 65 plans do not have any prescription drug benefits. To ensure prescription drug coverage, you will need to purchase a Medicare Part D policy, which is also available through BCBSVT. As an alternative, you have the option of switching from Vermont Blue 65 to a Carve-out plan which includes prescription drug coverage.

19. Do the VEHI health plan options cover nursing home care?

All plans provide skilled nursing facility (nursing home) care for acute conditions but should not be construed as "long-term care" insurance. Plans do not cover custodial care.

20. 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 provider when you've received emergency care. He or she will want to coordinate necessary follow-up care and ensure you get the appropriate treatment.

21. Can I get the JY or the Comprehensive plan for a cheaper rate if I opt not to have the prescription drug rider?

The JY and Comprehensive plans are not available without the prescription drug rider. Vermont Blue 65 is the only plan that does not include prescription drug coverage, so the only way to opt out of prescription drug coverage is to choose Vermont Blue 65.

22. Can I still get a three-month supply of medications at the pharmacy?

Three-month supplies are still available for certain medications. Discuss getting a prescription for a three-month supply with your physician if you are taking any medications on a long-term basis. You may be able to save a co-payment for a three-month supply by using the mail order program or a retail pharmacy that will accept the same reimbursement rate as our home delivery program. See page 8 for more details about your prescription drug benefits.

23. 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 18.

24. 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.

25. What plan options can I choose if I'm not eligible for Medicare yet?

You may choose any of the following plans if you are not eligible for Medicare:

- Vermont Health Partnership (see page 18)
- $300 Comprehensive (see page 20)
- JY Plan (see page 22)

A comparison of all of these options appears on page 24.

26. 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. Please note that your daughter may also purchase a product on Vermont Health Connect, the state's health benefits exchange. She may be eligible for premium assistance through the State of Vermont and the federal government. Vermont Health Connect can be an affordable alternative for young people who "age off" their parents' coverage.

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

Blue Cross and Blue Shield of Vermont does not limit coverage for pre-existing conditions on its group plans. You have coverage for pre-existing conditions.

28. I am not vested for a retirement health benefit, and I am not eligible for Medicare yet. What options do I have?

If you are a teacher or administrator, and did not work long enough to be vested for health benefits after retirement, but are vested for a pension, you may buy into the Vermont State Teachers' Retirement Services group plan, but you will not receive state subsidies to help pay costs.

You can also purchase health insurance coverage on Vermont Health Connect , the state's health care exchange. Depending on your household income, you may be eligible for federal and state subsidies. To buy coverage on Vermont Health Connect, visit http://info.healthconnect.vermont.gov/ or find a navigator near you. A list appears on the Vermont Health Connect website.

29. I am not vested for a retirement health benefit, but I am eligible for Medicare. What are my options?

If you are a teacher or administrator, and did not work long enough to be vested for health benefits after retirement, but are vested for a pension, you, too, may buy into the Vermont State Teachers' Retirement Services group plan, but you will not receive state subsidies to help pay costs.

Further, if you are in this position, you may want to consider a Medicare supplement product that you can buy directly from BCBSVT, as you may pay less for this type of plan. Support professionals who are not eligible for health care benefits may also purchase Medicare supplement plans. Call BCBSVT at (802) 371-3299.

Vermont Health Partnership *for retirees without Medicare*

<table>
<tr><th>Preferred Benefits</th><th>What You Pay</th><th>How to Obtain Preferred Benefits</th></tr>
<tr><td>In the primary care provider'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</td><td>▪ $15 co-payment
▪ For surgery in the office, one co-payment covers all pre- and post-operative visits</td><td>▪ Pick a primary care provider for yourself and each covered family member and use that doctor. The most current listing of primary care providers is available on our website at www.bcbsvt.com.</td></tr>
<tr><td>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)</td><td>▪ $25 co-payment</td><td>▪ 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.</td></tr>
<tr><td>OB-GYN office visits
▪ Gynecological care
▪ Pre-natal and post-natal maternity care</td><td>▪ $25 co-payment
▪ One co-payment covers all prenatal and postnatal maternity visits</td><td>▪ Use a network OB/GYN provider or get prior approval from BCBSVT.</td></tr>
<tr><td>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</td><td rowspan="4">▪ Covered in full</td><td>▪ 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.</td></tr>
<tr><td>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.</td><td>▪ Your condition must meet the criteria for an emergency medical condition in your Certificate of Coverage. See page 4 in this booklet for details.</td></tr>
<tr><td>Hospital Outpatient Care
▪ Outpatient surgery
▪ Lab, X-rays, EKG and other diagnostic services</td><td>▪ You may need prior approval (see page 6).</td></tr>
<tr><td>Hospital Outpatient Care
▪ Certain short-term therapies (e.g. physical, speech, occupational)</td><td>▪ Outpatient physical, speech and occupational therapy benefits are limited to 30 visits per year, combined.</td></tr>
<tr><td>Ambulance In-or Out-of-Service Area
▪ Ambulance service to the nearest facility in an emergency
▪ Nonemergency transfer between facilities</td><td>▪ $50 co-payment
▪ Limited to one co-payment per person, per day</td><td>▪ For emergency transport benefits, your condition must meet the criteria for an emergency medical condition in your Certificate of Coverage.
▪ Nonemergency treatment requires prior approval.</td></tr>
<tr><td>Home Care
▪ Skilled nursing visits, short-term therapy delivered in your home
▪ Private duty nursing</td><td>▪ $25 co-payment for private duty nursing
▪ All other home care is covered in full</td><td>▪ We limit private duty nursing benefits to $2,000 per calendar year.</td></tr>
</table>

Preferred Benefits	What You Pay	How to Obtain Preferred Benefits
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.
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, 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. There are no standard benefits for this service. ▪ You need prior approval before you buy certain drugs. See page 96 for details. ▪ See page 9 for details about how to save money with the convenient mail order service. ▪ 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.	▪ $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 66.
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 plan 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 provider 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 limit.*

$300 Deductible Comprehensive Plan *for retirees without Medicare*

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 ▪ Prenatal and postnatal 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 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 ▪ Nonemergency transfer between facilities		▪ 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.

<table>
<tr><th>Covered Services</th><th>What You Pay</th><th>How to Obtain Benefits</th></tr>
<tr><td>Home Care
- Skilled nursing visits, short-term therapy delivered in your home
- Private duty nursing</td><td rowspan="3">- 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.</td><td>- You may pay more out-of-pocket if you use a non-participating provider.
- We limit private duty nursing benefits to $2,000 per calendar year.</td></tr>
<tr><td>Chiropractic Care
- Services to treat a neuromusculoskeletal condition</td><td>- 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.</td></tr>
<tr><td>Mental Health and Substance Abuse Treatment
- Inpatient care
- Outpatient visits</td><td>- You need prior approval or,
- Call the prior approval number on the back of your ID card to initiate treatment.</td></tr>
<tr><td>Prescription Drugs
- Prescription drugs and antigens prescribed by a physician for FDA-approved uses
- Diabetic supplies, including test strips, insulin and syringes</td><td>- $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.</td><td>- 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 6 for details about the Prior Approval program.
- Your prescription co-payments do not count toward your medical out-of-pocket limit.</td></tr>
<tr><td>Medical Equipment and Supplies
- Supplies and equipment that have no non-medical use</td><td>- 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.</td><td>- You may pay more out-of-pocket if you use a Non-participating provider.
- See description of prior approval program on page 6.</td></tr>
<tr><td>Vision Exams</td><td>- No benefits</td><td>- No benefits</td></tr>
</table>

JY Plan *for retirees without Medicare*

<table>
<tr><th>Covered Services</th><th>What You Pay</th><th>How to Obtain Benefits</th></tr>
<tr><td>Office Visits
▪ Preventive care and well-child care
▪ Care by a specialist (for example, cardiologist, oncologist, OB/GYN, chiropractor, mental health provider)
▪ Emergency physician</td><td>▪ $20 co-payment</td><td>▪ 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.</td></tr>
<tr><td>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
▪ Prenatal and postnatal maternity care</td><td rowspan="6">▪ $0 (covered at 100 percent of the allowed amount)</td><td>▪ 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.</td></tr>
<tr><td>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</td><td>▪ Call for preadmission or admission review.
▪ See prior approval program description on page 6.
▪ Mental health and substance abuse treatment may require prior approval.</td></tr>
<tr><td>Hospital Emergency Care
Emergency 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.</td><td>▪ You may pay more out-of-pocket if you use a non-participating provider.</td></tr>
<tr><td>Hospital Outpatient Care
▪ Outpatient surgery
▪ Lab, X-rays, EKG and other diagnostic services
▪ Certain short-term therapies (e.g. physical, speech, occupational)</td><td>▪ 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.</td></tr>
<tr><td>Home Care
▪ Skilled nursing visits, short-term therapy delivered in your home</td><td>▪ You may pay more out-of-pocket if you use a non-participating provider.</td></tr>
</table>

<table>
<thead>
<tr><th>Covered Services</th><th>What You Pay</th><th>How to Obtain Benefits</th></tr>
</thead>
<tbody>
<tr><td>Private Duty Nursing</td><td rowspan="2">▪ $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.</td><td>▪ We limit private duty nursing benefits to $2,000 per calendar year.</td></tr>
<tr><td>Ambulance In-or Out-of-Service Area
▪ Ambulance service to the nearest facility in an emergency
▪ Nonemergency transfer between facilities</td><td>▪ Your condition must meet the criteria for an emergency medical condition in your Certificate of Coverage.
▪ 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.</td></tr>
<tr><td>Chiropractic Care
▪ Services to treat a neuromusculoskeletal conditions</td><td>▪ $20 co-payment</td><td>▪ 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.</td></tr>
<tr><td>Mental Health and Substance Abuse Treatment
▪ You may have to call to initiate treatment.</td><td>▪ Outpatient care: $20 co-payment
▪ Inpatient care: $0</td><td>▪ You need prior approval.
▪ Call the prior approval number on the back of your ID card to initiate treatment.</td></tr>
<tr><td>Prescription Drugs
▪ Prescription drugs and antigens prescribed by a physician for FDA-approved uses
▪ Diabetic supplies, including test strips, insulin and syringes</td><td>▪ $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.</td><td>▪ 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 6 for details about the prior approval program.
▪ Your prescription drug co-payments do not count toward your medical out-of-pocket limit.</td></tr>
<tr><td>Medical Equipment and Supplies
▪ Supplies and equipment that have no non-medical use</td><td>▪ $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.</td><td>▪ You may pay more out-of-pocket if you use a non-participating provider.
▪ See description of prior approval program on page 6.</td></tr>
<tr><td>Vision Exams</td><td>▪ No benefits</td><td>▪ No benefits</td></tr>
</tbody>
</table>

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

Comparison of Health Plans *for retirees without Medicare*

Selected Services	JY Plan	$300 Comprehensive	Vermont Health Partnership, Preferred Benefits
Primary Care Provider	You need not designate a primary care provider.		You must designate a network primary care physician upon enrollment.
Physician's Office Visits	▪ We pay all but your $20 office co-payment.	▪ You pay a $300 deductible (or up to a $600 family deductible), then 20% co-insurance until you reach your $600 individual (or $1,200 family out-of-pocket limit).	▪ We'll pay all but: ▪ $15 co-payment for visits with your primary care provider. ▪ $25 co-payment for visits with a specialty provider. ▪ Standard benefits are available for out-of-network services.
Prescription Drugs	You pay a $0 prescription drug deductible each year. Then you pay: ▪ a **$5** co-payment for generic drugs, ▪ a **$20** co-payment for preferred brand-name drugs ▪ a **$45** co-payment for non-preferred brand-name drugs		
Hospital Inpatient and Outpatient	▪ We pay 100% of our allowed amount.	▪ You pay a $300 deductible (or up to a $600 family deductible), then 20% co-insurance until you reach your $600 individual (or $1,200 family out-of-pocket limit).	▪ We pay 100% of our allowed amount. ▪ Standard benefits are available for out-of-network services.
Emergency Care	▪ You pay a $20 co-payment for the emergency room physician. ▪ Other hospital charges covered in full.	▪ You pay a $300 deductible (or up to a $600 family deductible), then 20% co-insurance until you reach your $600 individual (or $1,200 family out-of-pocket limit).	▪ We pay 100% of our allowed amount. ▪ No standard benefits.
Inpatient Mental Health Services	▪ We pay 100% of our allowed amount ▪ You **must** call to initiate treatment and use network providers.	▪ You pay a $300 deductible (or up to a $600 family deductible), then 20% co-insurance until you reach your $600 individual (or $1,200 family out-of-pocket limit). ▪ You **must** call to initiate treatment and use network providers.	▪ We pay 100% of our allowed amount. ▪ You **must** call to initiate treatment.
Outpatient Mental Health Services	▪ Same as physician's office visits (above). ▪ You **must** call to initiate treatment.	▪ You pay a $300 deductible (or up to a $600 family deductible), then 20% co-insurance until you reach your $600 individual (or $1,200 family out-of-pocket limit). ▪ You **must** call to initiate treatment and use a network provider.	▪ You pay a $25 co-payment each time you visit your provider's office. We cover the rest. ▪ You **must** call to initiate treatment.
Chiropractic Services	▪ $20 co-payment ▪ You **must** use a participating provider and get prior approval for any visits after 12 in a calendar year.	▪ You pay a $300 deductible (or up to a $600 family deductible), then 20% co-insurance until you reach your $600 individual (or $1,200 family out-of-pocket limit). ▪ You **must** use a participating provider and get prior approval for any visits after 12 in a calendar year.	▪ $25 co-payment for each visit. ▪ You **must** use a network provider. ▪ You also need prior approval for any visits after 12 in a calendar year. ▪ No standard benefits.

Comparison of Health Plans *for retirees with Medicare*

<table>
<tr><th>Selected Services</th><th>JY Carve-out Plan
Medicare pays the claim first. After Medicare, BCBSVT pays as described below.</th><th>Comprehensive Carve-out Plan
Medicare pays the claim first. After Medicare, BCBSVT pays as described below.</th><th>Vermont Blue 65 Plan C
Medicare pays the claim first. After Medicare, BCBSVT pays as described below.</th></tr>
<tr><td>Hospital Inpatient</td><td>▪ BCBSVT pays balances at 100% of allowed amount.
▪ Precertification program guidelines do not apply to the Carve-out plan.</td><td rowspan="3">▪ Medicare pays first. All Medicare balances are paid subject to your $300 Comprehensive deductible and 20% co-insurance up to your $600 out-of-pocket maximum.</td><td>▪ BCBSVT pays balances on Medicare-approved services. For example, Medicare pays all but your Part A deductible for the first 60 days and BCBSVT picks up your Part A deductible.</td></tr>
<tr><td>Hospital Outpatient</td><td>▪ BCBSVT pays balances at 100% of allowed amount.</td><td rowspan="2">▪ BCBSVT pays your Medicare Part B deductible, then Medicare pays 80% and BCBSVT pays 20% for the rest of the year. You pay nothing for Medicare-approved services, as long as your provider accepts Medicare's allowed amount as payment in full.</td></tr>
<tr><td>Physician's Office Visits</td><td>▪ BCBSVT pays all balances after your $20 co-payment.</td></tr>
<tr><td>Prescription Drugs</td><td colspan="2">$0 annual prescription drug deductible, then:
▪ a $5 co-payment for generic drugs,
▪ a $20 co-payment for preferred brand-name drugs
▪ a $45 co-payment for non-preferred brand-name drugs
▪ Out of pocket maximums for prescription drugs are $600 for an individual or $1,200 for a family.</td><td>▪ Neither Medicare Parts A and B nor Vermont Blue 65 Plan C covers prescription drugs, but show your BCBSVT card at most Vermont pharmacies and you'll receive a discount on the cost of your prescription. You must pay all charges.</td></tr>
<tr><td>Mental Health Outpatient Services</td><td>▪ BCBSVT pays balances (or the entire charge if Medicare makes no payment) according to the payment terms shown in "Physician's Office Visits," above.
▪ BCBSVT covers mental health services only if you call for prior approval.</td><td>▪ All Medicare balances are paid subject to your Comprehensive deductible and co-insurance.
▪ BCBSVT covers mental health services only if you call for prior approval.</td><td>▪ Medicare pays 50% of a particular allowed charge. BCBSVT covers the 50% balance. You must pay any amount over Medicare's allowance.</td></tr>
<tr><td>Chiropractic Services</td><td>▪ BCBSVT will cover balances (or the entire charge if Medicare makes no payment), less your $20 co-payment.
▪ You must use a participating chiropractor in order to receive benefits for chiropractic services. You must also obtain prior approval for any visits after 12 in a calendar year.</td><td>▪ BCBSVT covers balances (or the entire charge if Medicare makes no payment) subject to your $300 deductible, then 20% co-insurance up to your $600 out-of-pocket maximum.
▪ You must use a participating chiropractor in order to receive benefits for chiropractic services. You must also obtain prior approval for any visits after 12 in a calendar year.</td><td>▪ For Medicare-approved services, BCBSVT pays your Medicare deductible, then Medicare pays 80% and BCBSVT pays 20% for the rest of the year. You pay nothing as long as your provider accepts Medicare's allowance as payment in full. You must pay any amount over Medicare's allowance.
▪ BCBSVT does not cover charges Medicare denies. Check with Medicare to find out if they cover your chiropractic services.</td></tr>
</table>

*Your out-of-pocket limit does not include co-payments and deductibles you pay as part of the Prescription Drug Program. This is only a general outline of your benefits under these plans. Limits may apply. For specifics, please see your Contract, which may include your Certificate of Coverage and any accompanying riders.

*Notes: Medicare acts as your "Primary Payer" and pays first.

JY Plan Carve-out *for retirees with Medicare**

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 physician	▪ $20 co-payment	▪ See the next page for a description of your mental health and substance abuse treatment benefits. ▪ Use participating providers. If you use non-participating providers, you may pay more out-of-pocket expenses.
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 ▪ Surgery, casts, dressings administered in the office ▪ Prenatal and postnatal maternity care	▪ $0	▪ 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***	▪ $0	▪ 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 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	▪ $0	▪ You may pay more out-of-pocket if you use a non-participating provider.
Hospital Outpatient Care ▪ Outpatient surgery ▪ Labs, X-rays, EKG and other diagnostic services ▪ Certain short-term therapies (e.g. physical, speech, occupational)	▪ $0	▪ 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	▪ $0	▪ 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% 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 $2,000 per calendar year.
Ambulance In-or Out-of-Service Area ■ Ambulance service to the nearest facility in an emergency ■ Nonemergency transfer between facilities		■ Your condition must meet the criteria for an emergency medical condition in your Certificate of Coverage. ■ 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 condition	■ $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 must call to initiate treatment.	■ Outpatient Care: $20 co-payment ■ Inpatient Care: $0	You have managed mental health benefits: ■ Call BCBSVT for prior approval. ■ Use a network provider.
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 brand-name drugs that are on our preferred brand-name drug List, or ■ a **$45** co-payment for brand-name drugs that are not on our preferred brand-name drug list (non-preferred drugs). ■ Out of pocket maximums for prescription drugs are $600 for an 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 program. ■ You need prior approval before you buy certain drugs. See page 6 for details about the prior approval program.
Medical Equipment and Supplies ■ Supplies and equipment that have medical use only	■ $100 JY Plan deductible,* then ■ 20% 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

*Notes: Medicare acts as your "Primary Payer" and pays first. The JY Plan covers many of Medicare's balances in full. For certain services, you must meet your JY Plan deductible, then pay co-insurance up to your out-of-pocket limit while BCBSVT is covering balances.

$300 Comprehensive Carve-Out Plan *for retirees with Medicare*

<table>
<tr><th>Covered Services</th><th>What You Pay</th><th>How to Obtain Benefits</th></tr>
<tr><td>Office Visits
▪ Preventive care and well-child care
▪ Care by a specialist (for example, cardiologist, oncologist, OB/GYN, chiropractor, mental health provider)</td><td rowspan="7">▪ Medicare pays first and this carve-out plan considers any deductibles and other cost-sharing required by Medicare.
▪ Your cost-sharing for the carve-out plan includes a $300 deductible, then
▪ 20% of the allowed amount up to your $600 individual or $1,200 family out-of-pocket limit.
▪ Anything that Medicare pays on your behalf goes toward meeting the cost-sharing required by the carve-out plan.
▪ After you meet your out-of-pocket limit, you pay nothing after Medicare pays its share.</td><td>▪ 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.</td></tr>
<tr><td>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
▪ Surgery, casts, dressings administered in the office</td><td>▪ 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.</td></tr>
<tr><td>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</td><td>▪ See prior approval program description on page 6.
▪ See next page for a description of your mental health and substance abuse treatment benefits.</td></tr>
<tr><td>Hospital Outpatient Care
▪ Outpatient surgery
▪ Labs, X-rays, EKG and other diagnostic services
▪ Certain short-term therapies (e.g. physical, speech, occupational)</td><td>▪ 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.</td></tr>
<tr><td>Hospital Emergency Care
Emergency 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.</td><td>▪ You may pay more out-of-pocket if you use a non-participating provider.</td></tr>
<tr><td>Ambulance In-or Out-of-Service Area
▪ Ambulance service to the nearest facility in an emergency
▪ Non-emergency transfer between facilities</td><td>▪ 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.</td></tr>
</table>

Covered Services	What You Pay	How to Obtain Benefits
Home Care ▪ Skilled nursing visits, short-term therapy delivered in your home ▪ Private duty nursing	▪ Medicare pays first and this carve-out plan considers any deducitbles and other cost-sharing required by Medicare. ▪ Your cost-sharing for the carve-out plan includes a $300 deductible, then ▪ 20% of the allowed amount up to your $600 individual or $1,200 family out-of-pocket limit. ▪ Anything that Medicare pays on your behalf goes toward meeting the cost-sharing required by the carve-out plan. ▪ After you meet your out-of-pocket limit, you pay nothing after Medicare pays its share.	▪ You may pay more out-of-pocket if you use a non-participating provider. ▪ We limit private duty nursing benefits to $2,000 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		▪ Call BCBSVT for prior approval. ▪ Use a network provider. We do not cover services by out-of-network providers.
Prescription Drugs ▪ Prescription drugs and antigens prescribed by a physician for FDA-approved uses	▪ Medicare does not cover prescription drugs. ▪ $0 annual prescription drug deductible, then ▪ a **$5** co-payment for generic drugs, or ▪ a **$20** co-payment for brand-name drugs that are on our preferred brand-name drug list, or ▪ a **$45** co-payment for brand-name drugs that are not on our preferred brand-name drug list (non-preferred drugs). ▪ Out of pocket maximums for prescription drugs are $600 for an 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 program. ▪ You need prior approval before you buy certain drugs. See page 6 for details about the prior approval program.
Medical Equipment and Supplies ▪ Supplies and equipment that have medical use only	▪ Medicare pays first and this carve-out plan considers any deducitbles and other cost-sharing required by Medicare. ▪ Your cost-sharing for the carve-out plan includes a $300 deductible, then ▪ 20% of the allowed amount up to your $600 individual or $1,200 family out-of-pocket limit. ▪ Anything that Medicare pays on your behalf goes toward meeting the cost-sharing required by the carve-out plan. ▪ After you meet your out-of-pocket limit, you pay nothing after Medicare pays its share.	▪ 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 benefit	▪ No benefit.

*Notes: Medicare acts as your "Primary Payer" and pays first.

Vertmont Blue 65 Plan C *for retirees with Medicare*

Vermont Blue 65 Plan C pays for the portion of Medicare-allowed services that Medicare does not cover. Medicare deductibles and co-insurance vary from year to year. The chart below shows 2015 amounts. If you need a more up-to-date listing, please call Blue Cross and Blue Shield of Vermont for a current Outline of Coverage at (800) 247-2583.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization Room and board, services and supplies, etc.			
▪ First 60 days	All but $1,260*	$1,260* (Part A Deductible)	$0
▪ Days 61 through 90	All but $315 per day	$315 per day	$0
▪ Day 91 and after	All but $630 per day while using 60 lifetime reserve days, then $0.	$630 while using 60 reserve days, then 100%.	$0
Skilled Nursing Facility ▪ First 20 days ▪ Days 21 through 100 ▪ Day 101 and after	▪ All approved amounts ▪ All but $157.50 per day ▪ $0	▪ $0 ▪ Up to $157.50 per day ▪ $0	▪ $0 ▪ $0 ▪ All costs
Medical Expenses: In/Outpatient Physicians' services, covered therapy, diagnostic tests and durable medical equipment. ▪ First $147 of approved amounts* ▪ Remainder of approved amounts ▪ Part B excess (above approved amounts)	$0 80% $0	$147 20% $0	$0 $0 All costs
Clinical Laboratory Services Blood tests for diagnostic services	100%	$0	$0
Home Health Care ▪ Skilled care and medical supplies ▪ First $147 of Durable Medical Equipment (DME)* * Remainder of DME amounts	100% $0 80%	$0 $147 20%	$0 $0 $0
Prescription Drugs	Not covered	Not covered	All costs. Consider buying a Part D plan from BCBSVT.

Notes:

- A Medicare benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
- There is no prescription drug coverage with this plan.

*Once your $1,260 Part A deductible and your $147 Part B deductible have been paid, you will not have to meet any additional amounts for that calendar year.

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 in to the secure member site, where you can:

- check claims status
- look up your health plan benefits
- change your primary care provider
- use secure email to ask questions and receive answers 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 14 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 customer 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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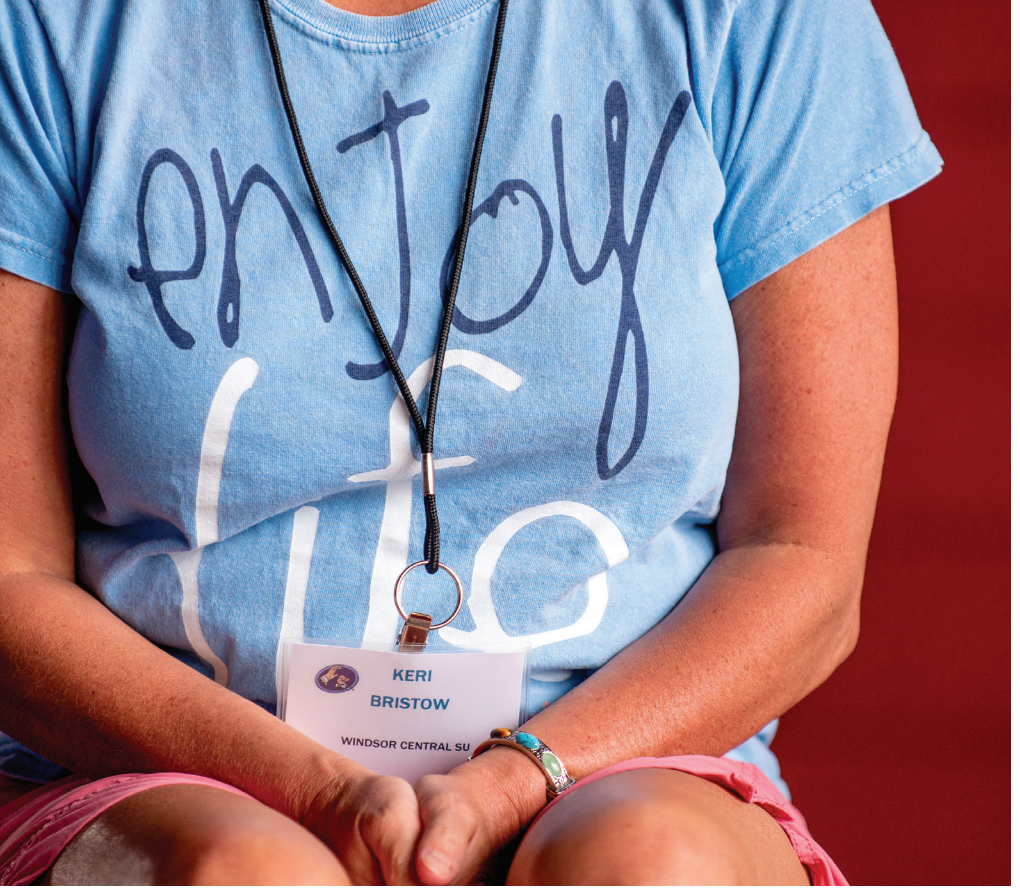


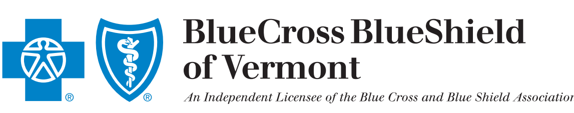
Contact BCBSVT, VEHI or VSTRS

Always call customer service at BCBSVT first when you need help with your health plan.

If you have general questions about your health plan and related matters, you can also call VEHI or speak with a retirement specialist at the Vermont State Teachers' Retirement System.

For your convenience, we list here frequently used telephone numbers, addresses and websites. Feel free to contact any of us when you need information or assistance.

VEHI's health benefit plans are administered by:



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

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 State Teachers' Retirement System	(800) 642-3191
Vermont Education Health Initiative	(802) 223-5040
24-Hour Nurse Hotline	(866) 612-0285
Pharmacy Network	(877) 493-1949
Blue Medicare Rx customer service	(855) 893-8538
TTY/TDD (prospective members)	(866) 552-6288
TTY/TDD (current members)	(866) 236-1069
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

Vermont State Teachers' Retirement System:
www.vermonttreasurer.gov/retirement/teachers-vstrs

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

284.253 (04/2015)

Changes to VEHI retiree enrollment guide

To: Vermont Education Health Initiative (VEHI) Members

FROM: Blue Cross and Blue Shield of Vermont and VEHI

DATE: April 4, 2016

RE: Changes to the document entitled *Benefits of the Vermont Education Health Initiative*

The benefits described in the ***Benefits of the Vermont Education Health Initiative for Retirees*** *booklet have changed slightly to ensure that our health plans are up to date and comply with state and federal requirements. In an effort to stay "green," use up our remaining stock of booklets before reprinting and save costs, we are providing you with this update on changes in the booklet.*

Please keep this document and note the following corrections:

- Some benefits charts in your enrollment guide state that you need prior approval for mental health and substance abuse services. Please **disregard** those notes. You **only** need prior approval for psychological testing, electro-shock therapy and inpatient, partial-inpatient or intensive outpatient mental health or substance abuse services. You do **not** need prior approval for any other mental health or substance abuse services.
- The list of other services for which you need prior approval has been updated and expanded, too. It includes the following, **in addition** to what you'll find on **page 7** of your booklet:
  - bilevel positive airway pressure (BPAP) equipment
  - hospital-grade electric breast pump
  - cochlear implants and aural rehabilitation
  - Durable Medical Equipment (DME) with a purchase price over $500
  - hip resurfacing
  - orthotics with a purchase price over $500
  - osteochondral autograph transfer system (OATS/mosaicplasty), and
  - radiation treatment and high-dose electronic brachytherapy.

  Please note that, while your booklet says you need prior approval for all prosthetics, you only need it for prosthetics with a purchase price over $500.
- Your health plan includes a mail service prescription drug service, which is described on **page 9**. If you use the home delivery service, you pay just two co-payments for a 90-day supply of the drug (which would otherwise require three co-payments). We want you to know that Vermont law provides that if a **retail pharmacy** agrees to the same terms and conditions as our mail order service, we must allow the retail pharmacy to fill your 90-day prescription for just two co-payments.
- **Page 13** is **out of date** with regard to the **"Marriage/civil union"** section, in that it refers to what happens when you enter a civil union. New civil unions are no longer allowed under Vermont law.
- The "Birth and Adoption" section on **page 15** states that when you add a newborn to your plan and your membership changes, the new membership type will be effective the first of the month after birth, placement for adoption or adoption. Currently, the new membership does not need to take effect **until 60 days after** birth, placement for adoption or adoption.