Vermont Education Health Initiative

Plan options for retirees and their dependents

VEHI's health benefit plans are administered by:

BlueCross BlueShield of Vermont

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

What is VEHI?

The Vermont Education Health Initiative (VEHI) *is a member-owned, non-profit organization that serves Vermont school districts and the Vermont State Teachers' Retirement System (VSTRS) by offering high-quality, affordable health plans responsive to the needs of employers, local unions, active and retired employees and their dependents.*

VEHI's health program has been operating for more than two decades. It is managed jointly by the Vermont School Boards Insurance Trust (VSBIT) and the Vermont-National Education Association (VT-NEA).

All funding for VEHI's health program comes from its members and is used to pay claims and costs associated with providing health benefits and wellness programs for school employees and retirees. Over 90 percent of all funding goes to pay actual claims; approximately 9 percent pays for BCBSVT administration of the program and state and federal taxes, assessments and fees. The remaining one percent funds VEHI's wellness program and administrative costs.

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

About this booklet

Dear former school employees,

We are committed to providing a range of benefit plans that are cost-effective, affordable and high quality. Our program invests in school-based and post-employment wellness programs that give you and your families the confidence, support and resources they need to lead healthy, productive lives. We are also intent on keeping school districts, local unions and VSTRS informed about the health care market, health care reform initiatives and regulatory compliance under federal and state law.

We urge you to consider yourself a purchaser of health care rather than a beneficiary of insurance. We believe involving you 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 and sustainable prices. Vermont schools, taxpayers, VSTRS and active school employees all benefit from the smart use of health care dollars.

Sincerely,

VEHI Management Team

*This booklet contains information about health benefit plans for retirees and their dependents (who meet eligibility standards) and is intended to help you make an educated choice regarding which health care plan suits you best. This booklet summarizes the benefits and the plans offered. For full information, you must consult your Summary of Benefits and Coverage (SBC) and a sample Benefits Description at **vehi.org**.*

Please note, this booklet is color coded for your convenience:

- blue is common information across all plans;
- yellow pertains to those who **do not** have Medicare; and
- green refers to plans for those **with** Medicare.

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VEHI coverage through VSTRS

Coverage for retirees

Coverage differs depending on whether you are enrolled in Medicare or not.

Coverage options without Medicare

- Vermont Health Partnership® Plan (VHP) (page 16)
- Comprehensive Plan (page 18)
- JY Plan (page 20)

Coverage options with Medicare

- Comprehensive Plan (page 28)
- JY Plan (page 30)
- VSTRS 65 Plan (page 32)—no Rx*

*__Please note__ that the VSTRS 65 Plan does not include prescription drug benefits. If you have that plan, you should consider buying a Part D plan directly through BCBSVT. See page 33.

General policy exclusions

You can be confident that your health plan covers a broad array of necessary services and supplies as described in this guide. 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 Benefit Description.
- Services that should be covered by another source, such as another type of insurance or an employer.
- Non-medical charges like fees for completion of a claim form, personal service items or home modifications.
- Visual, dental, auditory or podiatric services, unless specifically defined in your Benefit Description.
- Providers who are not approved to provide a particular service or who don't meet the definition of "provider" in your Benefit Description.

If you would like to review our complete list of General Exclusions before enrolling, please call the BCBSVT customer service team at (800) 344-6690.

Once you enroll in a plan, you will have access to your specific Benefit Description on our online Member Resource Center, which details all General Exclusions. Please read your Benefit Description carefully; it is a part of your contract which governs your benefits.

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

This document does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the government publication *Medicare and You* for more details.

Protecting your privacy

BCBSVT is 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/privacypolicies.** Or to request a paper copy, contact BCBSVT's customer service team at (800) 344-6690.

Membership information

Eligibility

Health insurance is available after retirement depending on your membership group, age, and years of service at retirement. For more information about your eligibility for health insurance, please contact the Vermont Retirement Office at (802) 828-2305 or toll free at (800) 642-3191.

Open enrollment

VEHI/VSTRS 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

If BCBSVT receives your request within 31 days after the date of marriage, your new type of membership begins the first day of the month following the date of marriage. If BCBSVT receives your request more than 31 days after the date of your marriage, your new membership begins the first day of the month after BCBSVT receives your request.

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

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

Birth or adoption

The Plan covers your child free of charge for the first 60 days after:

- birth;
- legal placement for adoption (if it occurs prior to adoption finalization); or
- legal adoption (when placement occurs when the adoption finalizes).

BCBSVT must receive your request for adding a dependent child to continue benefits for the child beyond the first 60 days. If BCBSVT receives your request within the 60 days:

- the child's effective date is retroactive to the date of birth, placement for adoption or adoption; and
- the new type of membership begins 60 days following birth, placement for adoption or adoption.

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

Dependent's Loss of Coverage

Any Dependents Covered under another health plan are eligible for coverage under the Plan if the Dependent loses his or her Group health coverage or ends employment. Within 31 days after loss of coverage, your Dependent may enroll on your current Plan, or you and your Dependents may change to any other Plan your employer offers. If you fail to add your Dependent within 31 days after loss of coverage, you must wait until an open enrollment date.

Court-ordered dependents

In the case of an order issued in compliance with your state's child medical support order laws, the effective date will be three days after you mail the court order to BCBSVT or when BCBSVT receives the court order, whichever is sooner. If the court order specifies a different effective date, BCBSVT will use that date. BCBSVT will calculate any additional premiums from the effective date of enrollment. Please remember your request for Dependent coverage under any court order must include proof of the court order.

Special enrollment rights under "CHIP"

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

You must request coverage no later than 60 days after losing coverage from Medicaid or Dr. Dynasaur. You may choose either the date coverage ends or the first of the month following BCBSVT's receipt of a valid enrollment request as the effective date for coverage under your group health plan.

You (and/or any dependent) must submit proof that you are eligible to enroll because one of the events above has occurred.

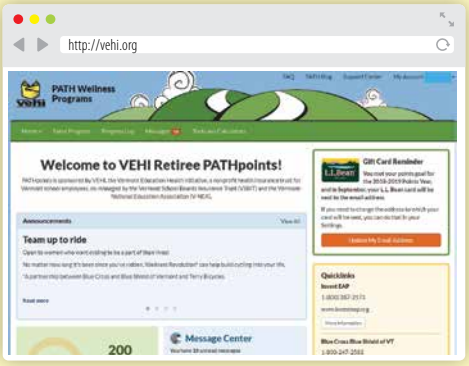
You may experience other special enrollment events. Please contact VSTRS with any questions or concerns regarding your or your dependent's eligibility.

*Certain restrictions may apply for enrolling in pharmacy benefits

Questions regarding enrollment or life events?

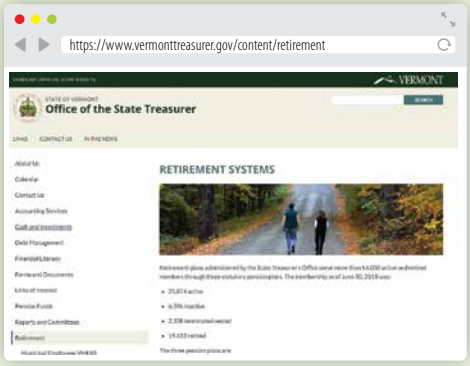
Contact Vermont State Teachers Retirement at (800) 642-3191.

Web resources



VEHI's Web resources

Visit **vehi.org** for the latest news and important developments regarding your plan. You can also find links to better understand your benefits, compliance resources, the PATH wellness program and how to contact us.

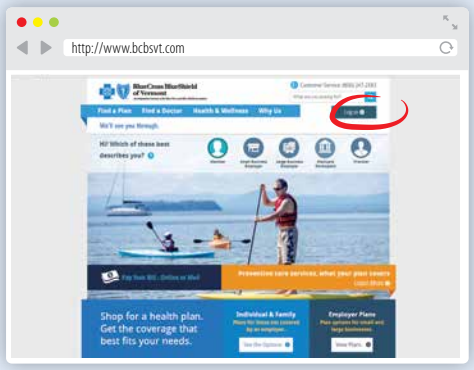


VSTRS:

Learn more about the Vermont State Teachers' Retirement System (VSTRS) by visiting **www.vermonttreasurer.gov/content/retirement/teacher**

Retiring TIMES
Vermont State Treasurer's Office

Keep up-to-date by reading the State Treasurer's Office biannual publication, *Retiring Times* at **www.vermonttreasurer.gov/retiringtimes**



BCBSVT's secure member site

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

- check claims status
- look up your health plan benefits
- check how many visit limits you have left in a calendar year for certain services such as chiropractic care or physical, speech and occupational therapy
- use secure e-mail to ask questions and hear back within 24 hours
- use Healthcare Advisor to compare cost and quality data on a variety of providers, services and supplies
- order ID cards

To gain entry to the member site, visit **www.bcbsvt.com/mrc** 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 (beginning after the three-letter prefix) followed by 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.

Wellness program for retirees

path
PLANNED ACTION TOWARD HEALTH

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 online.
- ✓ 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 mood. 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 safety information crossword puzzles 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 light-hearted family health goals and sharing them on our Facebook page to qualify 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.

Better care through Blue Health Solutions℠

Blue Health Solutions℠ *is our suite of free, customized health and wellness solutions designed to help you achieve and maintain optimal health at every stage of life.*

From our wellness solutions and tailored, integrated case management services to our popular health and wellness events throughout Vermont, we're here to support you at every stage of life. And we provide a local touch when it comes to our statewide events, case management services and health support for chronic and rare conditions—we're right here in your backyard!

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

Case management

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

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

Fitness and health events

Blue Cross and Blue Shield of Vermont holds many events each year that help Vermonters get out and get active. Our events range from walking challenges at Vermont worksites to "Hike, Bike & Paddle" events at Vermont lakes and ponds to "Apple Days" and "Snow Days" at some of our state's most beautiful venues. See the updated calendar at **www.bcbsvt.com/calendar**.

Blue Extras Health and Wellness Program℠

Our Blue Extras Health and Wellness Program gives your discounts on area health, fitness, nutrition and wellness resources—even recreational activities in your communities. To check out the growing list of discounted services and other items, visit **www.bcbsvt.com/blueextras**.

My Blue Health Wellness Center

By using **https://mybluehealth.bcbsvt.com**, you'll find the resources you need to help you take charge of your wellbeing. You can use My Blue Health on your mobile devices, making it easy to track while you're on the go. Our tool also offers:

- educational content;
- interactive wellness workshops;
- logs/trackers;
- fitness and diet plans; and
- exercise demos

Consumer support tools

Healthwise® Knowledgebase contains thousands of pages of information about health topics, or the Health Advisor, which helps you compare the price and quality of care from various providers.

Chronic Condition support

- ALS
- CIDP
- Crohn's Disease
- Cystic Fibrosis
- Dermatomyositis
- Gaucher Disease
- Hemophilia
- Lupus
- Multiple Sclerosis (MS)
- Myasthenia Gravis
- Parkinson's Disease
- Polymyositis
- Rheumatoid Arthritis
- Scleroderma
- Seizure Disorders
- Sickle Cell Disease
- Ulcerative Colitis
- Asthma
- COPD
- Diabetes
- Heart disease, or coronary disease
- Heart failure

More information about VEHI's PATH program

Please see page 7. You may also earn PATH points for engaging in one of the Blue Health Solutions programs!

path
PLANNED ACTION TOWARD HEALTH

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

Better Beginnings®

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

When a pregnant person enrolls in our program, one of our Better Beginnings nurses will work directly with them to identify any risks that could lead to complications while helping to reduce those risks. The program offers a choice of several different benefit options. We offer an enhanced benefit for those who enroll before the 34th week of pregnancy.

A sample of benefits includes:

- Homemaker services for house cleaning
- Reimbursements toward a car seat
- Reimbursements toward birthing or fitness classes
- The choice of a book from our specially selected Better Beginnings book list

Cancer support services

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

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

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

Addiction support services

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

- Speak with a registered nurse or licensed social worker as your single point of contact
- Get guidance about your substance use disorder treatment benefits—we don't look at just the medical diagnosis, we look at the "whole person" and take into consideration any co-occurring mental health and substance use disorder treatment requirements
- Receive information about local support groups, whether you are in recovery or you have a family member fighting addiction and you need additional support for yourself
- Find out about other local recovery resources

Transgender support services

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

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

End-of-life support services

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

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

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.

Your plan 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.

Our prior approval list changes periodically. For the most recent prior approval list, visit **www.bcbsvt.com/priorapproval** or call our customer service team at (800) 344-6690.

Telemedicine program

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

What is telemedicine?

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

- nutritional counseling
- breastfeeding support
- behavioral health services
- respiratory infections
- bronchitis
- urinary tract infections
- sore throat
- rashes
- pink eye
- cough
- flu
- stuffy nose
- allergies

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

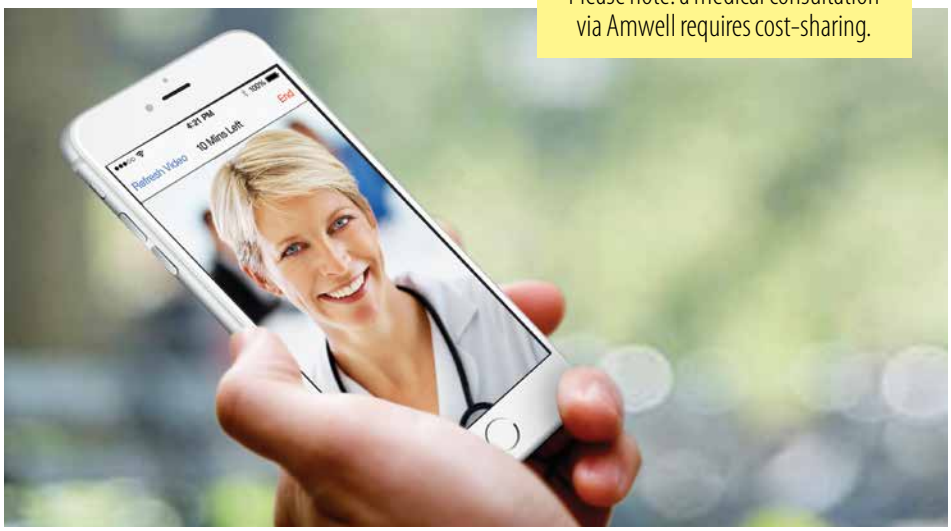
You can use Amwell when:

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

For more information, go to www.amwell.com or call Amwell customer service at (855) 818-3627.

Please note: telemedicine is not a covered benefit for VSTRS 65 Plan.

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



Helpful tips!

Register before you get sick!

This way, when illness hits, you are merely a finger tap away from getting the care you need. Visit **Amwell.com** to register or download the Amwell app from the App or Google Play™ store. If you have any questions about how the service works, please feel free to contact Amwell at (855) 818-3627.

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

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

Keep a list of important health care numbers on your fridge or family cork board.

It's a good idea to keep a list of important contact information such as how to access telemedicine services, the number for your primary care provider's office and your closest urgent care facility number on hand. When you're not feeling well, having these numbers handy helps save time and energy. In the case of an emergency, seek care right away by dialing 9-1-1.

Register today for Amwell® to get 24/7/365 medical advice.

There are three ways to sign up:

- Download the Amwell App from the iTunes Store® or Google Play™ store
- Visit **www.Amwell.com**
- Call **(844) 733-3627** (SEE-DOCS)

Telemedicine services provided by:

amwell

Blue Cross and Blue Shield of Vermont (BCBSVT) has contracted with American Well® (Amwell), an independent company, to provide telemedicine services for BCBSVT members. Amwell is solely responsible for its services and site content, as well as the conditions, terms of use and privacy policies that govern its site and services.

Emergency and urgent care

KNOW BEFORE YOU GO

Make the right care choice.

Be informed now so that you can choose the appropriate care for your situation. Understanding all your options may save you time and money.*

Get more information! Go to:
www.bcbsvt.com/knowbeforeyougo

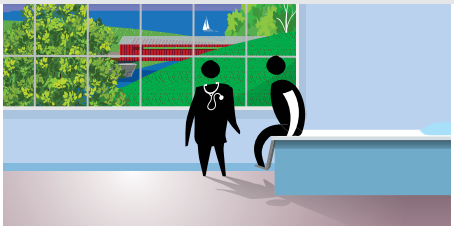
**Prior approval requirements and member benefits vary according to your plan. Before receiving services, please check your benefits as outlined in your member materials or by calling the number on the back of your ID card.*

Telemedicine services provided by:

amwell

Blue Cross and Blue Shield of Vermont (BCBSVT) has contracted with American Well® (Amwell), an independent company, to provide telemedicine services for BCBSVT members. Amwell is solely responsible for its services and site content, as well as the conditions, terms of use and privacy policies that govern its site and services.

Care options when it's *not* an emergency



Primary care provider

*Average costs** $$ *Average wait time* ⧖⧖

You should contact your regular provider for most urgent care and common health issues during office hours. Some examples are:

- infections
- cough
- digestive issues

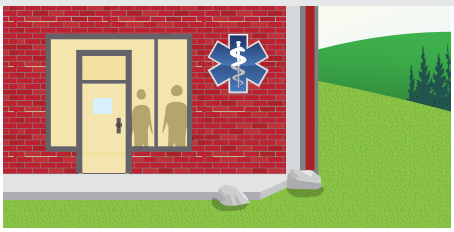
Telemedicine (amwell.com)

*Average costs** $-$$ *Average wait time* ⧖
Available 24 hours

You can access a clinician remotely for diagnosis and treatment via phone, video or other technologies. Commonly treated conditions:

- pink eye
- rash
- flu symptoms

When you need *immediate* attention



Urgent care center

*Average costs** $$$ *Average wait time* ⧖⧖

When you have a condition or illness that is not an emergency, but still needs quick attention, you could seek urgent care services. Urgent care could include treatment for:

- minor cuts
- minor back pain
- broken bones

Emergency room

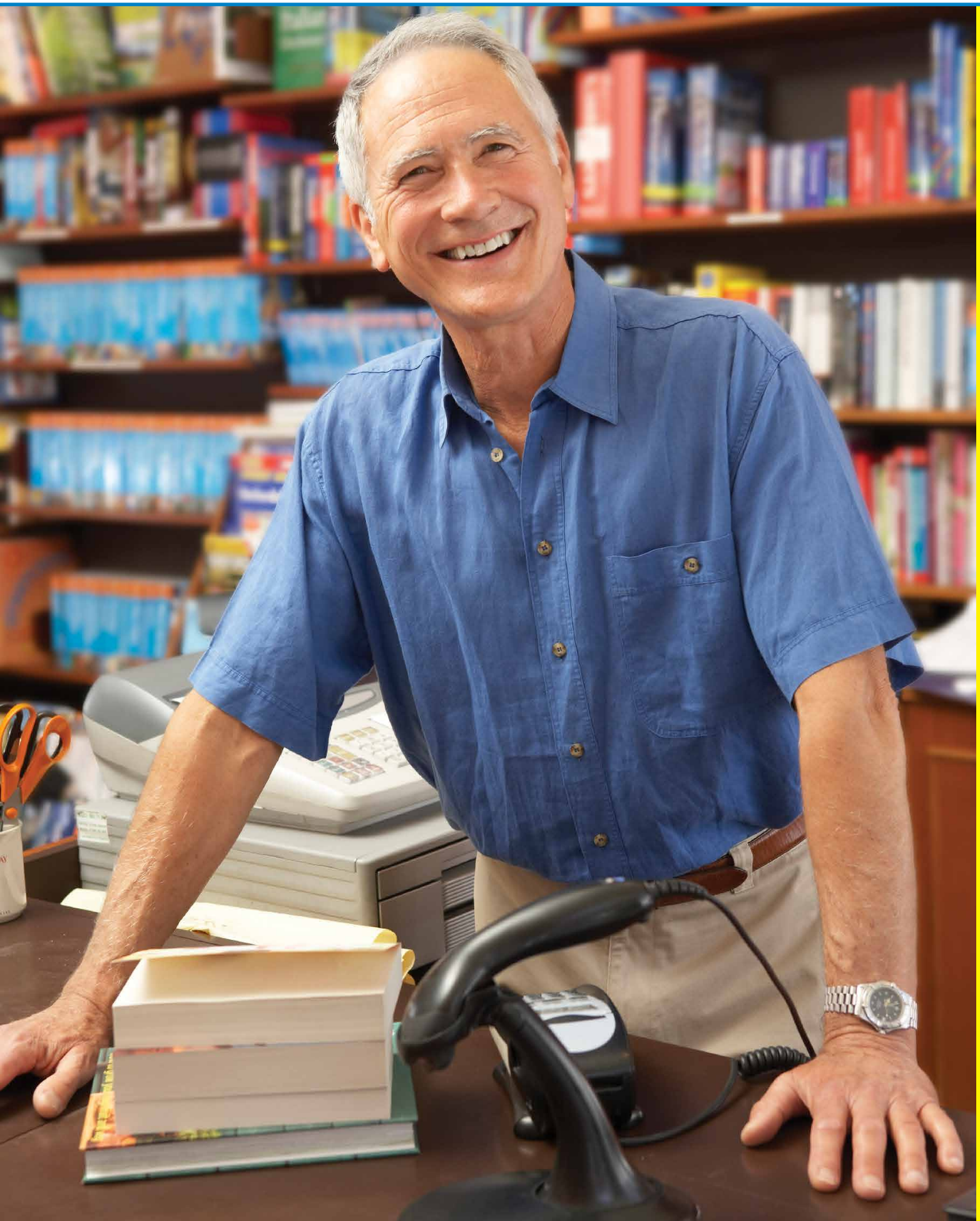
*Average costs** $$$$
Average wait time ⧖⧖⧖⧖
Available 24 hours

In an emergency, you need care right away. Emergencies might include:

- chest pains
- head injury with fainting
- injury to spine

If you have an emergency at home or away, call 9-1-1 or go to the nearest doctor or emergency department. You should call an ambulance if necessary.

Plans options for those *without* Medicare



Choosing providers

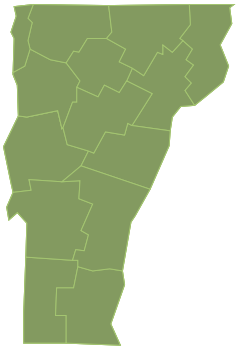
For those without Medicare coverage:

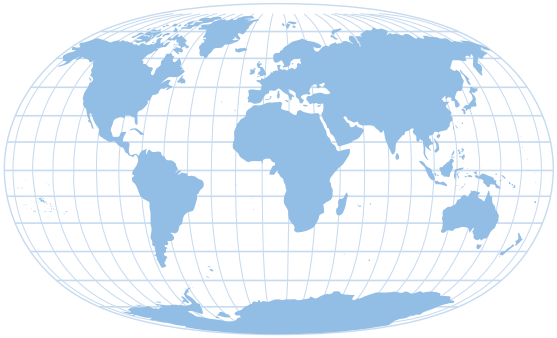
Finding a BCBSVT network provider

Finding a network provider is easy.

- Visit **www.bcbsvt.com/findadoctor** to find a provider in Vermont or contiguous counties.

If you have questions, call BCBSVT's customer service team at the number on the back of your ID card or the national provider finder line at (800) 810-BLUE (2583).





Steps to finding a BCBSVT provider in Vermont and contiguous counties

1. Visit **www.bcbsvt.com/findadoctor**.
2. Click "providers and hospitals in Vermont Service Area."
3. Once there, you may search by name or by provider type.
4. In the drop-down box marked "Network," select BCBSVT Network Providers.
   - Scroll down the page to refine your search.
   - You can search within a certain distance.
   - Look for providers of a certain gender or those who speak a certain language.
5. After your search results appear, find the printer icon and select "Print Search Results Directory" to create a printer-friendly file you can print or save to your computer.

If enrolling in the Vermont Heath Partnership (VHP), you must select a Primary Care Provider (PCP).

Be sure to find a provider who is accepting new patients.

Steps to finding national providers and providers around the globe through BCBSVT

Use the Find a Doctor tool to find national providers, hospitals and other providers in your plan's network. We encourage you to use this tool, rather than relying on out-of-state providers to advise you of whether or not they are in the network.

1. Go to **www.bcbsvt.com/findadoctor**.
2. Type in the first three letters (your alpha prefix) that appear in front of your member number on your ID card.
3. Your three-digit alpha prefix will signify what your provider network is. Yours will be the Traditional network.
4. Once you've selected your plan's appropriate network enter the type of provider you are seeking and your location, then click "Search."

Prescription drug plan

Rx co-payments

Your plan follows the Express Scripts/ BCBSVT National Preferred Formulary (NPF), and has a $0 deductible, then:

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

The National Preferred Formulary (NPF) can change and will be updated periodically to ensure that newer, more effective drugs are added. Reduce your out-of-pocket expenses by asking your physician to authorize a generic substitution whenever possible. This guarantees you the lowest co-payment.

Drug list updates

Drugs automatically come off the preferred brand-name drug list and are added to the generic lists when alternatives become available.

When a generic is not available, ask your provider if one of the drugs on the preferred brand-name drug list would be appropriate for you. These drugs can often meet patients' needs at a lower cost. A list of preferred brand-name drugs is available at the Rx Center of BCBSVT's website, **www.bcbsvt.com/pharmacy/drug-lists**

Benefit exceptions for excluded medications

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

Specialty medications

If you take specialty medications, you must get your specialty medications from the Accredo® Specialty Pharmacy Network. Prior authorization is required. Accredo's health care professionals provide expert guidance and care in specialty prescription medication. See **www.accredo.com/patients** for more information or call (844) 693-0163 to speak with a patient-care representative.

Convenient refills and savings with our home delivery program

If you use prescription drugs on an ongoing basis, Express Script's (ESI) home delivery service may be a less expensive, more convenient way for you to buy prescriptions. To begin using ESI's home delivery service for your maintenance drug, register at: **www.bcbsvt.com/pharmacy**.

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

Prior approval

BCBSVT's prior approval list changes periodically. The most current list can be found online or by calling ESI (see green box at right). Prior approval is required for drugs that have been on the market less than 12 months and/or medications without National Drug Code numbers. For example:

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

Quantity limits

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

BCBSVT's step therapy program saves members money by encouraging patients and their doctors to try less expensive drugs in a therapeutic class before using the newest, most expensive ones. 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®)

For more information and details on benefit exceptions, prior approval, quantity limits, or step therapy

Go to **www.bcbsvt.com/pharmacy** or call ESI toll-free **(877) 493-1949**

Vermont Health Partnership (VHP) *for members **without** Medicare*

Please note that this page contains only a summary of information. Your Benefit Description, your outline of coverage and your other contract documents govern your benefits.

In-network (preferred benefits)

- Your overall deductible is not applicable, but
  - Durable Medical Equipment (DME) and Supplies has a $100 individual deductible per member, per calendar year.
- Your overall out-of-pocket limit is not applicable.
- Your prescription drug deductible is $0.
- Your out-of-pocket limit for prescription drugs is $600 individual / $1,200 family per calendar year.

This plan requires you to list a primary care provider (PCP).

The benefits listed in this summary apply when you use network providers (preferred benefits) or get prior approval to go outside of the network. If you see an out-of-network provider (standard benefits), you may pay more out-of-pocket. For certain services you must use a in-network provider or there is no benefit.

Out-of-network (standard benefits)

- Your out-of-network deductible is $500 individual/$1,000 family per calendar year, then 30% co-insurance up to your $2,500 individual / $5,000 family out-of-pocket limit per calendar year.*
- For certain services you must use a network provider or there is no benefit. Please refer to the "Non-Network" section of your Benefits Description for a full listing of providers who must be in the network.

Service or Supply	Your Cost	Restrictions, Limitations or Other Important Information
Preventive Care	**Preventive care office visits with PCP**: $15 co-payment per visit **Colorectal and mammogram screenings**: No charge	Preventive care benefits must meet the plan's definition of screening/preventive. For screening mammograms, you may use network or non-participating Providers and obtain network benefits.
Office Visits	**Primary care provider office visits**: $15 co-payment per visit **Specialist office visits** (e.g. cardiologist, gynecologist, oncologist, nutritionist, chiropractor): $25 co-payment per visit **Outpatient physical, occupational and speech therapy**: $25 co-payment per visit	Certain provider specialties must be network or there is no benefit. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined, per calendar year. Prior approval required after 12 physical therapy visits per calendar year. You must use a network chiropractor and requires prior approval after 12 visits per calendar year. For Nutritional Counseling you must use a network provider, benefits are covered up to three visits per calendar year. There is no limit on the number of nutritional counseling visits for treatment of diabetes.
Ambulance Services	$50 co-payment per member per day	Your condition must meet the criteria for an emergency medical condition in your Benefits Description. All non-emergency ambulance transport requires prior approval. You must get prior approval within 48 hours of non-emergency air and water transport.
Emergency Care	No charge	Your condition must meet the criteria for an emergency medical condition in your Benefits Description. For emergency care, you may use network or non-participating providers and obtain network benefits.
Urgent Care	$25 co-payment per visit	For urgent care in a facility, you may use network and non-participating providers and obtain network benefits. Your condition must meet the criteria for urgent services as defined in your Benefits Description.
Home Health and Hospice Care Services	No charge	Private duty nursing is covered up to 14 hours per member per calendar year, subject to a $25 co-payment per visit.

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

Service or Supply	Your Cost	Restrictions, Limitations or Other Important Information
Inpatient and Outpatient Care in a Hospital	No charge	You must get prior approval for out-of-network inpatient care. Some surgeries, diagnostic, inpatient and outpatient services require prior approval.
Medical Equipment and Supplies	Deductible, then 20% co-insurance	Some medical equipment and supplies may require prior approval. Diabetic medication and supplies are not subject to deductible, co-insurance, or co-payment.
Care During Pregnancy	**Inpatient delivery**: No charge **Office visit**: $25 co-payment per visit	For maternity, one co-payment covers all pre-natal and post-natal office visits by one network provider. Other services and tests may take additional cost-sharing. Members enrolled in our Better Beginnings program receive extra benefits.
Rehabilitation and Skilled Nursing Facility Care	**Inpatient treatment**: No charge **Outpatient cardiac or pulmonary rehabilitation**: No charge	You must get prior approval for inpatient rehabilitations. This benefit does not cover care in a non-network physical rehabilitation facility.
Telemedicine Services through Amwell®	**Acute care**: $15 co-payment per visit **MH/SUD:** $25 co-payment per visit **Nutritional counseling**: $25 co-payment per visit	For telemedicine consultations you must use an Amwell provider, visit **www.Amwell.com**.
Vision Care	**Adult and Pediatric exam**: $20 co-payment **Adult and Pediatric materials**: Not covered	One routine vision exam per member, per calendar year. This benefit does not cover the evaluation and fitting of contact lenses or other supplemental tests.

How Your Pharmacy Coverage Works

Some prescription drugs require prior approval. You must use a network pharmacy. Find a network pharmacy at **www.bcbsvt.com/findadoctor**.

Prescription Drugs: Retail and Home Delivery		
Generic Drugs	**Retail:** $5 co-payment per 30-day supply **Home delivery pharmacy:** $5 co-payment per 30-day supply $10 co-payment per 60 or 90-day supply	Prescription out-of-pocket: $600 individual / $1,200 family per calendar year. No charge for diabetic medications and supplies obtained through your prescription drug benefit.
Preferred Brand Drugs	**Retail:** $20 co-payment per 30-day supply **Home delivery pharmacy:** $20 co-payment per 30-day supply $40 co-payment per 60 or 90 -day supply	
Non-Preferred Brand Drugs	**Retail:** $45 co-payment per 30-day supply **Home delivery pharmacy:** $45 co-payment per 30-day supply $90 co-payment per 60 or 90-day supply	

* If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

Comprehensive Plan *for members **without** Medicare*

- Your overall deductible is $300 individual / $600 family per calendar year.*
- Your overall out-of-pocket limit is $600 individual / $1,200 family per calendar year.
- Your prescription drug deductible is $0.
- Your out-of-pocket limit for prescription drugs is $600 individual / $1,200 family per calendar year.

Please note that this page contains only a summary of information. Your Benefit Description, your outline of coverage and your other contract documents govern your benefits.

Service or Supply	Your Cost	Restrictions, Limitations or Other Important Information
Preventive Care	**Preventive care office visits:** Deductible, then 20% co-insurance **Colorectal and mammogram screenings:** No charge	Preventive care benefits must meet the plan's definition of screening/preventive. For screening mammograms, you may use network or non-participating Providers and obtain network benefits.
Office Visits	**Primary care provider office visits:** Deductible, then 20% co-insurance **Specialist office visits** *(e.g. cardiologist, gynecologist, oncologist, nutritionist, chiropractor)*: Deductible, then 20% co-insurance **Outpatient physical, occupational and speech therapy:** Deductible, then 20% co-insurance	Certain provider specialties must be network or there is no benefit. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined, per calendar year. Prior approval required after 12 physical therapy visits per calendar year. You must use a network chiropractor and requires prior approval after 12 visits per calendar year. For Nutritional Counseling you must use a network provider, benefits are covered up to three visits per calendar year. There is no limit on the number of nutritional counseling visits for treatment of diabetes.
Ambulance Services	Deductible, then 20% co-insurance	Your condition must meet the criteria for an emergency medical condition in your Benefits Description. All non-emergency ambulance transport requires prior approval. You must get prior approval within 48 hours of emergency air and water transport.
Emergency Care	Deductible, then 20% co-insurance	Your condition must meet the criteria for an emergency medical condition in your Benefits Description. For emergency care, you may use network or non-network providers and obtain network benefits.
Urgent Care	Deductible, then 20% co-insurance	For urgent care in a facility, you may use network and non-participating providers and obtain network benefits. Your condition must meet the criteria for urgent services as defined in your Benefits Description.
Home Health and Hospice Care Services	Deductible, then 20% co-insurance	Private duty nursing is covered up to 14 hours per member per calendar year.
Inpatient and Outpatient Care in a Hospital	Deductible, then 20% co-insurance	You must get prior approval for out-of-state inpatient care. Some surgeries, diagnostic, inpatient and outpatient services require prior approval.

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

Service or Supply	Your Cost	Restrictions, Limitations or Other Important Information
Medical Equipment and Supplies	Deductible, then 20% co-insurance	Some medical equipment and supplies may require prior approval. Diabetic medication and supplies are not subject to deductible, co-insurance, or co-payment.
Care During Pregnancy	**Inpatient delivery:** Deductible, then 20% co-insurance **Office visit:** Deductible, then 20% co-insurance	Members enrolled in our Better Beginnings program receive extra benefits.
Rehabilitation and Skilled Nursing Facility Care	**Inpatient treatment:** Deductible, then 20% co-insurance **Outpatient cardiac or pulmonary rehabilitation**: Deductible, then 20% co-insurance	You must get prior approval for inpatient rehabilitations. This benefit does not cover care in a non-participating physical rehabilitation facility.
Telemedicine Services through Amwell	**Acute care**: Deductible, then 20% co-insurance **MH/SUD**: Deductible, then 20% co-insurance **Nutritional counseling**: Deductible, then 20% co-insurance	For telemedicine consultations you must use an Amwell provider, visit **www.Amwell.com**.
Vision Care	**Adult and Pediatric exam**: Not covered **Adult and Pediatric materials**: Not covered	Please see your Benefit Description for optometry services to treat a disease condition.

How Your Pharmacy Coverage Works

Some prescription drugs require prior approval. You must use a network pharmacy. Find a network pharmacy at **www.bcbsvt.com/findadoctor**.

Prescription Drugs: Retail and Home Delivery		
Generic Drugs	**Retail:** $5 co-payment per 30-day supply **Home delivery pharmacy:** $5 co-payment per 30-day supply $10 co-payment per 60 or 90-day supply	Prescription out-of-pocket: $600 individual / $1,200 family per calendar year. No charge for diabetic medications and supplies obtained through your prescription drug benefit.
Preferred Brand Drugs	**Retail:** $20 co-payment per 30-day supply **Home delivery pharmacy:** $20 co-payment per 30-day supply $40 co-payment per 60 or 90 -day supply	
Non-Preferred Brand Drugs	**Retail:** $45 co-payment per 30-day supply **Home delivery pharmacy:** $45 co-payment per 30-day supply $90 co-payment per 60 or 90-day supply	

* If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

- Your overall deductible is not applicable
- Your other deductibles are:
  - $100 per individual up to a maximum of three member deductibles per family per calendar year for ambulance services, infusion therapy, medical equipment and supplies, orthotics, prosthetics, and private duty nursing.
- Your overall out-of-pocket limit is $600 per member, per calendar year.
- Your prescription drug deductible is $0.
- Your out-of-pocket limit for prescription drugs is $600 individual/$1,200 family per calendar year.

Please note that this page contains only a summary of information. Your Benefit Description, your outline of coverage and your other contract documents govern your benefits.

Service or Supply	Your Cost	Restrictions, Limitations or Other Important Information
Preventive Care	**Preventive care office visits:** $20 co-payment per visit **Colorectal and mammogram screenings:** No charge	Preventive care benefits must meet the plan's definition of screening/preventive. For screening mammograms, you may use network or non-network Providers and obtain network benefits.
Office Visits	**Primary care provider office visits:** $20 co-payment per visit **Specialist office visits** *(e.g. cardiologist, gynecologist, oncologist, nutritionist, chiropractor)*: $20 co-payment per visit **Outpatient physical, occupational and speech therapy**: No charge	Certain provider specialties must be network or there is no benefit. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined, per calendar year. Prior approval required after 12 physical therapy visits per calendar year. You must use a network chiropractor and requires prior approval after 12 visits per calendar year. For Nutritional Counseling you must use a network provider, benefits are covered up to three visits per calendar year. There is no limit on the number of nutritional counseling visits for treatment of diabetes.
Ambulance Services	Deductible, then 20% co-insurance	Your condition must meet the criteria for an emergency medical condition in your Benefits Description. All non-emergency ambulance transport requires prior approval. You must get prior approval within 48 hours of emergency air and water transport.
Emergency Care	**Facility**: No charge **Provider**: $20 co-payment per visit	Your condition must meet the criteria for an emergency medical condition in your Benefits Description. For emergency care, you may use network or non-participating providers and obtain network benefits.
Urgent Care	$20 co-payment per visit	For urgent care in a facility, you may use network and non-participating providers and obtain network benefits. Your condition must meet the criteria for urgent services as defined in your Benefits Description.
Home Health and Hospice Care Services	No charge	Private duty nursing is covered up to 14 hours per member per calendar year.

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

Service or Supply	Your Cost	Restrictions, Limitations or Other Important Information
Inpatient and Outpatient Care in a Hospital	No charge **Mental Health/Substance Use Disorder outpatient**: $20 co-payment per visit **Mental Health/Substance Use Disorder Intensive outpatient**: No charge	You must get prior approval for out-of-state inpatient care. Some surgeries, diagnostic, inpatient and outpatient services require prior approval.
Medical Equipment and Supplies	Deductible, then 20% co-insurance	Some medical equipment and supplies may require prior approval. Diabetic medication and supplies are not subject to deductible, co-insurance, or co-payment.
Care During Pregnancy	**Inpatient delivery:** No charge **Office visit:** No charge	Members enrolled in our Better Beginnings program receive extra benefits.
Rehabilitation and Skilled Nursing Facility Care	**Inpatient treatment:** No charge **Outpatient cardiac or pulmonary rehabilitation**: No charge	You must get prior approval for inpatient rehabilitations. This benefit does not cover care in a non-network physical rehabilitation facility.
Telemedicine Services through Amwell	**Acute care**: $20 co-payment per visit **MH/SUD**: $20 co-payment per visit **Nutritional counseling**: $20 co-payment per visit	For telemedicine consultations you must use an Amwell provider, visit **www.Amwell.com**.
Vision Care	**Adult and Pediatric exam**: Not covered **Adult and Pediatric materials**: Not covered	Please see your Benefit Description for optometry services to treat a disease condition.

How Your Pharmacy Coverage Works

Some prescription drugs require prior approval. You must use a network pharmacy. Find a network pharmacy at **www.bcbsvt.com/findadoctor**.

Prescription Drugs: Retail and Home Delivery		
▪ Generic Drugs	**Retail:** $5 co-payment per 30-day supply **Home delivery pharmacy:** $5 co-payment per 30-day supply $10 co-payment per 60 or 90-day supply	Prescription out-of-pocket: $600 individual / $1,200 family per calendar year. No charge for diabetic medications and supplies obtained through your prescription drug benefit.
▪ Preferred Brand Drugs	**Retail:** $20 co-payment per 30-day supply **Home delivery pharmacy:** $20 co-payment per 30-day supply $40 co-payment per 60 or 90 -day supply	
▪ Non-Preferred Brand Drugs	**Retail:** $45 co-payment per 30-day supply **Home delivery pharmacy:** $45 co-payment per 30-day supply $90 co-payment per 60 or 90-day supply	

Plan Comparison *for members **without** Medicare*

Selected Services	Vermont Health Partnership (VHP), Preferred Benefits	Comprehensive	JY Plan
Primary Care Provider	**Yes**—You must designate a valid Primary Care Provider (PCP) upon enrollment.	**No**—You do not need designate a Primary Care Provider (PCP).	
Preventive Care (colorectal and mammogram screenings: No charge)	PCP: $15 co-payment per visit	You pay a $300 individual/ $600 family deductible, then 20% co-insurance until $600 individual/ $1,200 family out-of-pocket limit per calendar year.	$20 co-payment per visit
Office Visits	PCP: $15 co-payment per visit Specialist: $25 co-payment per visit		PCP: $20 co-payment per visit Specialist: $20 co-payment per visit
Emergency and Urgent Care	Emergency care: No charge Urgent care: $25 co-payment per visit		Urgent care and ER Provider: $20 co-payment per visit.
Home Health, Rehabilitation and Skilled Nursing Facility Care	No charge		No charge
Inpatient and Outpatient Care in a Hospital	No charge MH/SUD primary care: $15 co-payment per visit MH/SUD specialist: $25 co-payment per visit		No charge MH/SUD primary care: $20 co-payment per visit MH/SUD specialist: $20 co-payment per visit
Telemedicine Services through AmWell®	Acute Care: $15 co-payment per visit Speciality Care: $25 co-payment per visit		Acute and Speciality Care: $20 co-payment per visit
Medical Equipment and Supplies	$100 deductible per member per calendar year, then 20% co-insurance		$100 individual deductible up to a maximum of three member deductibles per family per calendar year.
Vision Exam	$20 co-payment, one per member, per calendar year	Not covered	
Prescription Drugs	You have a $0 prescription drug deductible. 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 Your out-of-pocket maximum is $600 for an individual or $1,200 for a family per calendar year.		

This comparison contains only summary information. Your Benefit Description, outline of coverage and other contract documents govern your benefits. Questions? Call BCBSVT at (800) 344-6690.

Plan Comparison *for retirees **with** Medicare*

Selected Services	Comprehensive	JY Plan	VSTRS 65
You must be enrolled in Medicare Parts A and B to be eligible for these plans. *Medicare pays the claim first. After Medicare, the plan pays as described below.*			
Primary Care Provider	**No**—You do not need designate a Primary Care Provider.		
Preventive Care	Medicare pays first, then any Medicare balances are subject to your $300 deductible, then 20% co-insurance until your $600 out-of-pocket limit per calendar year.	You pay $20 co-payment per visit	You pay nothing for Medicare-approved services, as long as your provider accepts Medicare's allowed amount as payment in full.
Office Visits		You pay $20 co-payment per visit	
Emergency and Urgent Care		You pay $20 co-payment per visit	
Home Health, Rehabilitation and Skilled Nursing Facility Care		No charge	Home Health and Rehabilitation: For Medicare-approved services, you pay nothing Skilled Nursing Facility Care: You pay nothing through 100 days, then you pay 100%
Inpatient and Outpatient Care in a Hospital		No charge MH/SUD: $20 co-payment per visit	Inpatient: Generally, you pay nothing** Outpatient: You pay nothing for Medicare-approved services, as long as your provider accepts Medicare's allowed amount as payment in full.
Telemedicine Services through AmWell®	You pay a $300 deductible, then 20% co-insurance until your $600 out-of-pocket limit per calendar year.	$20 co-payment per visit	Not covered
Medical Equipment and Supplies	Medicare pays first, then any Medicare balances are subject to your $300 individual deductible, then 20% co-insurance until your $600 out-of-pocket limit per calendar year.	$100 deductible per calendar year.	For Medicare-approved services, you pay nothing.
Vision Exam	Not covered		
Prescription Drugs	You have a $0 prescription drug deductible. 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 Your out-of-pocket maximum is $600 for an individual or $1,200 for a family per calendar year.		**Not covered.** *You must purchase a Medicare Part D Prescription Drug Plan independently.*

**When your Medicare Part A hospital benefits are exhausted, the plan stands in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid. Beyond the additional 365 days, you pay 100%.

This comparison contains only summary information. Your Benefit Description, outline of coverage and other contract documents govern your benefits. Questions? Call BCBSVT at (800) 344-6690.

Introduction to plan options *with* Medicare

Three smart steps to quality health care after retirement:

STEP 1 Medicare Parts A & B + STEP 2 VSTRS Medicare plan + STEP 3 Prescription Drug Plan = peace of mind

What is Medicare?

Medicare is the federal health insurance program for:

- people 65 or older,
- people under 65 with certain disabilities, and
- people of any age with End-Stage Renal Disease (ESRD).

How do you enroll?

For Medicare Parts A and B, call Social Security toll-free at (800) 772-1213 (TTY: (800) 325-0778). You can also set up an appointment at your local Social Security office. You'll need to provide proof of age, such as a birth certificate.

For additional information, contact Medicare at (800) MEDICARE [TTY users (877) 486-2048], 24 hours a day, 7 days a week.

STEP 1 Medicare Parts A & B

Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) are managed by the Federal Government and help cover specific services.

Be sure to plan ahead. Call the Social Security office as soon as you make your retirement decision.

You will need both Medicare Parts A and B to be eligible for a VSTRS Medicare Plan.

Medicare Part A—

Hospital insurance covers:

- Hospital care
- Care in a skilled nursing facility
- Hospice care
- Some home health care

For most individuals, Medicare Part A (hospital insurance) is free. If neither you nor your spouse has paid Medicare taxes for at least 10 years, you will need to pay a monthly premium. (You can find this amount in the "Your Medicare Costs" section at **www.medicare.gov**.)

Medicare Part B—

Medical insurance covers:

- Doctor and other health care providers' services
- Outpatient care (medical care or treatment that does not require an overnight stay in a hospital or medical facility)
- Durable medical equipment
- Home health care
- Some preventive services (such as flu shots and yearly wellness visits)

Part B requires a monthly premium, which can come right out of your Social Security check.

STEP 2

VSTRS Medicare plan

Choose a VSTRS Medicare plan that works best for you

The VSTRS plans offered to those with Medicare provide assistance with costs not paid by Medicare, like co-insurance, co-payments and deductibles.

	JY Plan	Comprehensive Plan	VSTRS 65
Office visits	☑ Yes	☑ Yes	☑ Yes
Hospital inpatient & outpatient	☑ Yes	☑ Yes	☑ Yes
Emergency care	☑ Yes	☑ Yes	☑ Yes
Prescription drugs	☑ Yes	☑ Yes	☒ **No**

To find a doctor that accepts Medicare:

To find a doctor that accepts Medicare payments, visit the **Medicare.gov** Physician Compare. You can search by entering a health care professional's last name or group practice name, a medical specialty, a medical condition, a body part, or an organ system. This tool will provide you with a list of professionals or group practices in the specialty and geographic area you specify, along with detailed profiles, maps and driving directions.

You may also call **1-800-MEDICARE** and a representative will be able to run the search for you. They can even send you a print version of the search results.

STEP 3

Prescription Drug Plan

Finally, complete your coverage with prescription drug coverage:

If enrolling in Comprehensive or JY Plan:

Your plan already ***includes*** prescription drug coverage, therefore there is no need to purchase an additional prescription drug plan—**see pages 26-27**.

If enrolling in the VSTRS 65 plan:

Your plan ***does not*** include prescription drug coverage. You will need to purchase a Part D prescription drug plan on your own—**see page 33**.

When your enrollment is complete—you will have three ID cards:

- Medicare (Parts A and B)
- Blue Cross and Blue Shield of Vermont (medical)
- Pharmacy (Blue MedicareRx)

Prescription drug plans *for JY and Comprehensive Plans*

*Prescription drug program for members enrolling in a **JY** or **Comprehensive** plan*

If you are enrolled in Medicare Part A and Part B and enrolling in a JY or Comprehensive Plan, your plan includes prescription drug benefits. You will receive your prescription drug benefits through the **Blue Medicare Rx**[SM] **prescription drug plan (PDP)**. You will use the Blue MedicareRx (PDP) network of pharmacies here in Vermont and nationwide.*

Pharmacy network

Almost all Vermont pharmacies and a large percentage of pharmacies nationwide currently belong to the Blue MedicareRx network. Most major chains (e.g. Walgreen's, 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. Members who are TTY/TDD members should call 711.

Present your Blue MedicareRx ID card at a network pharmacy and the pharmacist will file a claim for you.

Please note that your Blue MedicareRx pharmacy card is separate from your BCBSVT medical ID card and your Medicare card.

Rx co-payments

Your plan has a $0 deductible, then:

- $5 co-payment for generic drugs
- $20 for brand-name drugs on Blue MedicareRx formulary
- $45 for drugs not on the Blue MedicareRx formulary

The Blue MedicareRx formulary can change and will be updated periodically. 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. You can find the current formulary at **http://groups.rxmedicareplans.com**.

Your out-of-pocket costs for Blue MedicareRx are the same as the VSTRS plans without Medicare.

Convenient refills and savings with Blue MedicareRx's home delivery program

If you use prescription drugs on an ongoing basis, Blue MedicareRx's home delivery service may be a less expensive, more convenient way for you to buy prescriptions. To begin using home delivery service for your maintenance drug, send Blue MedicareRx's mail order pharmacy your doctor's prescription, an order form (available online or by phone) and any required cost-sharing amounts. For cost-sharing details, please see **Rx co-payments** to the left.

Contact information

Blue MedicareRx

Web: **http://groups.rxmedicareplans.com**

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

TTY/TDD: 711
24 hours a day, seven days a week.

***Please note** that the VSTRS 65 Plan does not include prescription drug benefits. If you are currently on the VSTRS 65 plan, you should consider buying a Part D plan directly through BCBSVT. See page 33.

Prior authorizations and step therapy

Our goal is to provide our members with access to the safest, most effective, and reasonably priced drugs available. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan rules encourage you and your prescriber to use the lower-cost option. These rules comply with Medicare regulations and help keep your drug coverage more affordable.

Prior authorization

Some prescription drugs require prior authorization. This means that before your plan will cover a particular drug, your doctor or prescriber must contact Blue MedicareRx to explain why the drug is medically necessary for you.

Step Therapy

With step therapy, you must first try a certain less expensive drug before you can move up a "step" to a more expensive drug. For example, Blue MedicareRx may require you to try a generic drug before your plan will cover a more expensive brand-name drug.

You could get an exception to step therapy if:

- You've already tried a similar or less expensive drug and it didn't work
- Your doctor or prescriber believes your condition requires use of a certain drug, even if it is more expensive

Exceptions

Exceptions can be granted when Blue MedicareRx determines that a requested drug is medically necessary. A doctor's statement must be submitted with all such requests. The two types of exceptions are:

- A tiering exception can be requested to obtain a drug at a lower cost share
- A formulary exception can be requested to obtain a drug that's not on our list or if you believe restrictions such as step therapy on a certain drug should not apply

Your physician may request an exception or get prior authorization by filling out the Physician Coverage Determination Request Form. Your physician will need to fax this form to Blue MedicareRx at (855) 633-7673.

Blue Cross and Blue Shield of Vermont, in a joint venture with three other New England Blue plans, contracts with the Federal Government to offer Medicare prescription drug coverage, called Blue MedicareRx℠ (PDP).

Blue Cross and Blue Shield of Vermont, in a joint venture with three other New England Blue plans, contracts with the Federal Government to provide Part D benefits.

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx (PDP) plans. The joint enterprise is a Medicare-approved Part D Sponsor. Enrollment in BlueMedicareRx (PDP) depends on contract renewal.

Comprehensive Plan *for retirees **with** Medicare*

- Your overall deductible is $300 individual / $600 family per calendar year.
- Your overall out-of-pocket limit is $600 individual / $1,200 family per calendar year.
- Your prescription drug deductible is $0.
- Your out-of-pocket limit for prescription drugs is $600 individual / $1,200 family per calendar year.

Please note that this page contains only a summary of information. Your Benefit Description, your outline of coverage and your other contract documents govern your benefits.

Service or Supply	Your Cost	Restrictions, Limitations or Other Important Information
Preventive Care	**Preventive care office visits:** Deductible, then 20% co-insurance **Colorectal and mammogram screenings:** No charge	Preventive care benefits must meet the plan's definition of screening/preventive. For screening mammograms, you may use network or non-network Providers and obtain network benefits.
Office Visits	**Primary care provider office visits:** Deductible, then 20% co-insurance **Specialist office visits** *(e.g. cardiologist, gynecologist, oncologist, nutritionist, chiropractor)*: Deductible, then 20% co-insurance **Outpatient physical, occupational and speech therapy:** Deductible, then 20% co-insurance	Certain provider specialties must be network or there is no benefit. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined, per calendar year. Prior approval required after 12 physical therapy visits per calendar year. You must use a network chiropractor and requires prior approval after 12 visits per calendar year. For Nutritional Counseling you must use a network provider, benefits are covered up to three visits per calendar year. There is no limit on the number of nutritional counseling visits for treatment of diabetes.
Ambulance Services	Deductible, then 20% co-insurance	Your condition must meet the criteria for an emergency medical condition in your Benefits Description. All non-emergency ambulance transport requires prior approval. You must get prior approval within 48 hours of emergency air and water transport.
Emergency Care	Deductible, then 20% co-insurance	Your condition must meet the criteria for an emergency medical condition in your Benefits Description. For emergency care, you may use network or non-network providers and obtain network benefits.
Urgent Care	Deductible, then 20% co-insurance	For urgent care in a facility, you may use network and non-network providers and obtain network benefits. Your condition must meet the criteria for urgent services as defined in your Benefits Description.
Home Health and Hospice Care Services	Deductible, then 20% co-insurance	Private duty nursing is covered up to 14 hours per member per calendar year.
Inpatient and Outpatient Care in a Hospital	Deductible, then 20% co-insurance	You must get prior approval for out-of-state inpatient care. Some surgeries and diagnostic services require prior approval. Some inpatient and outpatient services require prior approval.

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

Service or Supply	Your Cost	Restrictions, Limitations or Other Important Information
Medical Equipment and Supplies	Deductible, then 20% co-insurance	Some medical equipment and supplies may require prior approval. Diabetic medication and supplies are not subject to deductible, co-insurance, or co-payment.
Care During Pregnancy	**Inpatient delivery:** Deductible, then 20% co-insurance **Office visit:** Deductible, then 20% co-insurance	Members enrolled in our Better Beginnings program receive extra benefits.
Rehabilitation and Skilled Nursing Facility Care	**Inpatient treatment:** Deductible, then 20% co-insurance **Outpatient cardiac or pulmonary rehabilitation**: Deductible, then 20% co-insurance	You must get prior approval for inpatient rehabilitations. This benefit does not cover care in a non-network physical rehabilitation facility.
Telemedicine Services through Amwell	**Acute care**: Deductible, then 20% co-insurance **MH/SUD**: Deductible, then 20% co-insurance **Nutritional counseling**: Deductible, then 20% co-insurance	For telemedicine consultations you must use an Amwell provider, visit **www.Amwell.com**.
Vision Care	**Adult and Pediatric exam**: Not covered **Adult and Pediatric materials**: Not covered	Please see your Benefit Description for optometry services to treat a disease condition.

How Your Pharmacy Coverage Works

Some prescription drugs require prior approval. You must use a network pharmacy. Find a network pharmacy at **http://groups.rxmedicareplans.com**.

Prescription Drugs: Retail and Home Delivery		
Generic Drugs	**Retail:** $5 co-payment per 30-day supply **Home delivery pharmacy:** $5 co-payment per 30-day supply $10 co-payment per 60 or 90-day supply	Prescription out-of-pocket: $600 individual / $1,200 family per calendar year. No charge for diabetic medications and supplies obtained through your prescription drug benefit.
Preferred Brand Drugs	**Retail:** $20 co-payment per 30-day supply **Home delivery pharmacy:** $20 co-payment per 30-day supply $40 co-payment per 60 or 90 -day supply	
Non-Preferred Brand Drugs	**Retail:** $45 co-payment per 30-day supply **Home delivery pharmacy:** $45 co-payment per 30-day supply $90 co-payment per 60 or 90-day supply	

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

- Your overall deductible is not applicable
- Your other deductibles are:
  - $100 per individual up to a maximum of three member deductibles per family per calendar year for ambulance services, infusion therapy, medical equipment and supplies, orthotics, prosthetics, and private duty nursing.
- Your overall out-of-pocket limit is $600 per member, per calendar year.
- Your prescription drug deductible is $0.
- Your out-of-pocket limit for prescription drugs is $600 individual/$1,200 family per calendar year.

Please note that this page contains only a summary of information. Your Benefit Description, your outline of coverage and your other contract documents govern your benefits.

Service or Supply	Your Cost	Restrictions, Limitations or Other Important Information
Preventive Care	**Preventive care office visits:** $20 co-payment per visit **Colorectal and mammogram screenings:** No charge	Preventive care benefits must meet the plan's definition of screening/preventive. For screening mammograms, you may use network or non-network Providers and obtain network benefits.
Office Visits	**Primary care provider office visits:** $20 co-payment per visit **Specialist office visits** *(e.g. cardiologist, gynecologist, oncologist, nutritionist, chiropractor)*: $20 co-payment per visit **Outpatient physical, occupational and speech therapy**: No charge	Certain provider specialties must be network or there is no benefit. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined, per calendar year. Prior approval required after 12 physical therapy visits per calendar year. You must use a network chiropractor and requires prior approval after 12 visits per calendar year. For Nutritional Counseling you must use a network provider, benefits are covered up to three visits per calendar year. There is no limit on the number of nutritional counseling visits for treatment of diabetes.
Ambulance Services	Deductible, then 20% co-insurance	Your condition must meet the criteria for an emergency medical condition in your Benefits Description. All non-emergency ambulance transport requires prior approval. You must get prior approval within 48 hours of emergency air and water transport.
Emergency Care	**Facility**: No charge **Provider**: $20 co-payment per visit	Your condition must meet the criteria for an emergency medical condition in your Benefits Description. For emergency care, you may use network or non-network providers and obtain network benefits.
Urgent Care	$20 co-payment per visit	For urgent care in a facility, you may use network and non-network providers and obtain network benefits. Your condition must meet the criteria for urgent services as defined in your Benefits Description.

Service or Supply	Your Cost	Restrictions, Limitations or Other Important Information
Home Health and Hospice Care Services	No charge	Private duty nursing is covered up to 14 hours per member per calendar year.
Inpatient and Outpatient Care in a Hospital	No charge **Mental Health/Substance Use Disorder outpatient**: $20 co-payment per visit **Mental Health/Substance Use Disorder Intensive outpatient**: No charge	You must get prior approval for out-of-state inpatient care. Some surgeries and diagnostic services require prior approval. Some inpatient and outpatient services require prior approval.
Medical Equipment and Supplies	Deductible, then 20% co-insurance	Some medical equipment and supplies may require prior approval. Diabetic medication and supplies are not subject to deductible, co-insurance, or co-payment.
Care During Pregnancy	**Inpatient delivery:** No charge **Office visit:** No charge	Members enrolled in our Better Beginnings program receive extra benefits.
Rehabilitation and Skilled Nursing Facility Care	**Inpatient treatment:** No charge **Outpatient cardiac or pulmonary rehabilitation**: No charge	You must get prior approval for inpatient rehabilitations. This benefit does not cover care in a non-network physical rehabilitation facility.
Telemedicine Services through Amwell	**Acute care**: $20 co-payment per visit **MH/SUD**: $20 co-payment per visit **Nutritional counseling**: $20 co-payment per visit	For telemedicine consultations you must use an Amwell provider, visit **www.Amwell.com**.
Vision Care	**Adult and Pediatric exam**: Not covered **Adult and Pediatric materials**: Not covered	Please see your Benefit Description for optometry services to treat a disease condition.

How Your Pharmacy Coverage Works

Some prescription drugs require prior approval. You must use a network pharmacy. Find a network pharmacy at **http://groups.rxmedicareplans.com**.

Prescription Drugs: Retail and Home Delivery		
Generic Drugs	**Retail:** $5 co-payment per 30-day supply **Home delivery pharmacy:** $5 co-payment per 30-day supply $10 co-payment per 60 or 90-day supply	Prescription out-of-pocket: $600 individual / $1,200 family per calendar year. No charge for diabetic medications and supplies obtained through your prescription drug benefit.
Preferred Brand Drugs	**Retail:** $20 co-payment per 30-day supply **Home delivery pharmacy:** $20 co-payment per 30-day supply $40 co-payment per 60 or 90 -day supply	
Non-Preferred Brand Drugs	**Retail:** $45 co-payment per 30-day supply **Home delivery pharmacy:** $45 co-payment per 30-day supply $90 co-payment per 60 or 90-day supply	

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

VSTRS 65 for retirees with Medicare—*No prescription drug coverage*

VSTRS 65 Plan 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 **2019** amounts. If you need a more up-to-date listing, please call Blue Cross and Blue Shield of Vermont at (800) 344-6690 or refer to your current Outline of Coverage.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization (Room and board, services and supplies, etc.)			
First 60 days	All but $1,364*	$1,364* (Part A Deductible)	$0
61st through 90th days	All but $341 per day	$341 per day	$0
91st day and after, while using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
Once lifetime reserve days are used: additional 365 days	$0	100% of Medicare-eligible expenses	$0
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility			
First 20 days	All approved amounts	$0	$0
21st through 100th days	All but $170.50 per day	Up to $170.50 per day	$0
101st day and after	$0	$0	All costs
Medical Expenses: In/Outpatient Physicians' services, covered therapy, diagnostic tests and durable medical equipment.			
First$185 (Part B Deductible) of approved amounts*	$0	$185 (Part B Deductible)	$0
Remainder of approved amounts	Generally 80%	Generally 20%	$0
Part B excess (above approved amounts)	$0	$0	All costs
Clinical Laboratory Services Blood tests for diagnostic services	100%	$0	$0
Home Health Care (Medicare-approved services)			
Skilled care and medical supplies	100%	$0	$0
First $185 of Durable Medical Equipment (DME)*	$0	$185 (Part B deductible)	$0
	80%	20%	$0
Prescription Drugs	**Not covered.** *You must purchase a Medicare Part D Prescription Drug Plan independently.*	**Not covered.** *You must purchase a Medicare Part D Prescription Drug Plan independently.*	**All costs.** *Consider purchasing a Medicare Part D Prescription Drug Plan from BCBSVT.* **See page 33.**

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 2019 Part A deductible and your Part B deductible have been paid, you will not have to meet any additional amounts for that calendar year. Please note: Medicare deductibles and co-insurance vary from year to year. Please call BCBSVT customer service at the number on the back of your ID card for the Part A and Part B amounts.

**Remainder of Medicare-approved amounts.

Prescription drug options available for VSTRS 65

Note: Only available to VSTRS 65 enrollees—not available to JY or Comprehensive Plan enrollees.

STEP 3: Part D drug coverage

(only if enrolling in VSTRS 65 Plan)

The final component of the equation is Medicare prescription drug coverage (Part D). Medicare Part D plans are offered by insurance companies approved by Medicare and are available to anyone who is entitled to Medicare Part A and/or enrolled in Part B.

Part D adds drug coverage to original Medicare and covers both brand-name and generic prescription drugs at network pharmacies in your area. (Note: Part D typically does not cover over-the-counter medications.)

You must enroll in Medicare Part D through an insurance company and pay a monthly premium. Each plan can vary in costs (premiums, deductibles, co-payments and drugs covered).

You should consider enrolling in a drug plan unless you will already have drug coverage that is at least as good as Medicare Part D prescription drug coverage.

How do you enroll?

To get Medicare drug coverage, you must join a Medicare drug plan through a Prescription Drug Plan (PDP). Plans vary in cost and drugs covered. To compare plans go to **www.medicare.gov**.

You are eligible to enroll three months before, during, or three months after the month your Medicare coverage begins *or* during the open enrollment period each year between October 15 to December 7.

It is important to investigate your options now. If you wait, you may have to pay more for your coverage later.

Part D late enrollment penalty: unless you are eligible for extra help with paying your Medicare costs, you may owe a late enrollment penalty. The cost of the late enrollment penalty depends on how long you went without Part D or creditable prescription drug coverage, and is added to the cost of your monthly Part D premiums.

Part D options with BCBSVT

Blue Cross and Blue Shield of Vermont, in a joint venture with three other New England Blue plans, contracts with the Federal Government to provide Part D benefits under the name Blue MedicareRx℠ (PDP).

You can learn more about BCBSVT plans and eligibility requirements at **www.rxmedicareplans.com**. You may also call the Blue MedicareRx (PDP) team at (888) 496-4174, TTY: 711 (24 hours a day, 7 days a week).

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx (PDP) plans. The joint enterprise is a Medicare-approved Part D Sponsor. Enrollment in BlueMedicareRx (PDP) depends on contract renewal.

Notice of privacy practices

How BCBSVT protects your privacy

We are required by law to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You have the right to gain access to your health information and to information about BCBSVT's privacy practices.

In general, BCBSVT's notice of privacy practices explains:

- BCBSVT's routine use and disclosure of personal health information (PHI);
- The internal protection of oral, written and electronic PHI; and
- The protection of information disclosed to plan sponsors or to employers.

A complete copy of BCBSVT's Notice of Privacy Practices is available at **www.bcbsvt.com/privacypolicies.** Or to request a paper copy, contact BCBSVT's customer service team at the phone number listed on the back of your ID card

How VEHI protects your privacy and security

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

You have received this notice because you receive medical and/or dental insurance coverage under a health benefits plan offered by the Vermont Education Health Initiative ("VEHI") and/or you participate in VEHI's wellness programs. VEHI is an inter-municipal insurance association that is approved and overseen by the Vermont Department of Financial Regulation. VEHI offers non-insured, self-funded health benefit plans, wellness programs and compliance services to schools and other educational organizations in Vermont. The enrollees of VEHI's health benefits plan are active and retired school employees and their dependents. VEHI's health benefit plans are financed by employer and/or employee contributions.

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

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

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

Use and disclosure of your protected health information (PHI)

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

To make or obtain payment.

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

To conduct health care operations.

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

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

For example, we may use and disclose your protected health information to conduct case management, quality improvement, utilization review and provider credentialing activities or to engage in customer service and grievance

Notice of privacy practices *(cont'd)*

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.

Notice of privacy practices

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:

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

Notice of privacy practices *(cont'd)*

Right to an accounting.

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

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

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

Right to a paper copy of this notice.

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

Right to file complaints.

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

Appointment reminders and fundraising

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

Our duties with respect to your protected health information

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

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

Potential impact of state law

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

Contact person

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

Effective date

This Notice is effective September 1, 2013, with non-material revisions on May 1, 2017.

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.

NOTICE: Discrimination is against the law

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

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

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

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

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

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

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

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

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

ARABIC

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

CHINESE

如需免費語言協助服務，請致電(800) 247-2583。

CUSHITE (OROMO)

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

FRENCH

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

GERMAN

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

ITALIAN

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

JAPANESE

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

NEPALI

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

PORTUGUESE

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

RUSSIAN

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

SERBO-CROATIAN (SERBIAN)

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

SPANISH

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

TAGALOG

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

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE

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

Notes

Contact us

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

If you have eligibility or membership questions about your plan, please call a retirement specialist at the Vermont State Teachers' Retirement System at (802) 828-2305 or toll free at (800) 642-3191.

For your convenience, we list here frequently used telephone numbers, addresses and websites.

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

Vermont State Teachers' Retirement System

Office of the State Treasurer
109 State Street, Floor 4
Montpelier, VT 05609-6200

PHONE

BCBSVT Customer Service	(800) 344-6690
Vermont National Education Association (Vermont NEA)	(802) 223-6375
Vermont State Teachers' Retirement System	(802) 828-2305
or toll free	(800) 642-3191
Vermont Education Health Initiative	(802) 223-5040
ESI Pharmacy Network	(877) 493-1949
Blue Medicare Rx customer service	(855) 893-8538
TTY/TDD (current members)	711
Case management/prior approval	(800) 922-8778
Medicare	(800) 633-4227
Social Security	(800) 772-1213

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/content/retirement/teacher

Pharmacy Networks:
Express Scripts: www.express-scripts.com

Blue MedicareRx:
http://groups.rxmedicareplans.com

Telemedicine Services:
www.amwell.com

Medicare:
www.medicare.gov

Social Security:
www.ssa.gov

IN PERSON

Blue Cross and Blue Shield of Vermont

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

Vermont State Teachers' Retirement System

Office of the State Treasurer
109 State Street, Floor 4
Montpelier, VT 05609-6200

VEHI's health benefit plans are administered by:

BlueCross BlueShield of Vermont

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

284.253 (09/2019)