vehi

Introduction to 2018 Benefit Programs for Active Employees

We'll see you through.

BlueCross BlueShield of Vermont

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

What's inside

The health plans of the Vermont Education Health Initiative (VEHI) are changing in 2018. Inside, you'll find information about the plans and services available to you.

For more information about the changes to VEHI plans for 2018, visit the VEHI website at www.vehi.org or email Vehi2018@vsbit.org.

How to use this guide

We have created this guide to introduce Vermont Education Health Initiative (VEHI) members to benefits plans scheduled for 2018. Inside, you'll find:

About VEHI today

What is VEHI?

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

VEHI is committed to:

- Making available a range of employee benefit plans that are cost-effective, affordable and high quality;
- Designing and investing in school-based and post-employment wellness programs that give individuals and families the confidence, support and resources they need to lead healthy, productive lives; and
- Keeping school districts, local union associations and VSTRS informed about the health care market, health care reform initiatives and regulatory compliance under federal and state law.

VEHI urges its members to view themselves as purchasers of health care rather than as beneficiaries of insurance. We believe involving consumers directly in the purchasing of health care services provides the necessary link between providers and consumers that can ensure high-quality products and services at affordable and sustainable prices. Vermont schools, taxpayers, VSTRS and school employees, active and retired, all benefit from the smart use of health care dollars.

Why change VEHI's health benefits for 2018?

In 2010, President Obama signed into law the Affordable Care Act (ACA) and Vermont began preparations not only to build a health care exchange required by the ACA, but to move toward further reforms. At that time, Governor Peter Shumlin proposed a universal, publicly financed health care system for 2017 called Green Mountain Care (GMC). If GMC had come to pass, it would have replaced the state exchange (Vermont Health Connect). School districts would then have made the transition to Green Mountain Care. VEHI had "grandfathered" its health plans in 2010, as permitted under the ACA, in anticipation of GMC.

Vermont has decided for now not to move toward the GMC single-payer system. In order for VEHI, therefore, to be viable, credible, sustainable and competitive in the market, especially with respect to benefit offerings, cost-sharing options and health care spending accounts, VEHI decided to design new, non-grandfathered health plans that are fully compliant with the ACA.

The new plans address the cost pressures on school budgets, local tax payers and school employees, and provide the opportunity for all parties to save premium dollars. They also give employees the option of setting aside health care dollars in tax-favored, healthcare spending accounts. Lastly, these plans will preserve the flexibility and security of having an exclusive health benefit pool for school employees, active and retired. VEHI's new plans are a good-faith effort to be true to its historical mission and remain competitive in a health insurance market that has been fundamentally altered by the ACA and Vermont Health Connect.

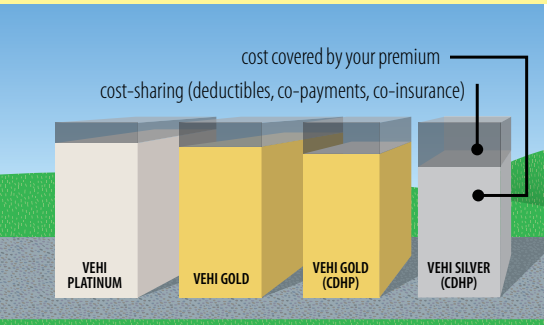
About the ACA

The Affordable Care Act (ACA), which became federal law in 2010, fundamentally changed the way health care is financed in the United States. Though Vermont, which has long used community rating, experienced less change than some states, Vermonters did see some changes to their health plans. Among them:

- Health plans can no longer deny or limit coverage to members with pre-existing conditions; however, Americans must maintain coverage or face penalties at tax time.*
- Parents can now include children on their memberships until those young adults turn age 26, whether or not they marry or live at home and regardless of whether they are students.*
- Lifetime and annual limits for essential benefits and coverage rescissions by insurers have been prohibited since 2010.*
- Employers with plans that started in advance of the passage of the ACA could maintain those plans with limited ACA requirements as long as they did not substantially change them. VEHI's pre-2018 plans were among these "grandfathered plans."
- States set up "exchanges" that provide coverage for individuals and groups of 100 or fewer employees. Vermont set up its own exchange, Vermont Health Connect, and became the only state to mandate that small groups buy plans qualified for the exchange.
- Health plans must offer preventive care governed by the United States Preventive Services Task Force with no cost-sharing by members. Preventive services include certain women's health services—among them contraceptives. VEHI's 2018 plans will include these features.
- Certain limits apply to cost-sharing on essential benefits. In 2017, members' out-of-pocket limits cannot exceed $7,150 for individual coverage or $14,300 for family coverage.*
- Waiting periods imposed by employers, that is, the period from employees' hire dates until the time they're eligible for benefits (also called probationary periods), may not exceed 90 days.
- Health plans and employers must use standardized "Summaries of Benefits and Coverage" when initially presenting coverage to employees.*

**VEHI plans already adopted these components.*

What's new and what stays the same?



VEHI coverage:

Beginning in 2018, VEHI will offer four health plans:

- **VEHI Platinum** with a $500 deductible (HRA compatible) – see page 8
- **VEHI Gold** with a $1,200 deductible (HRA compatible) – see page 9
- **VEHI Gold CDHP** with a $1,800 deductible (HRA and HSA compatible) – see page 12
- **VEHI Silver CDHP** with a $3,000 deductible (HRA and HSA compatible) – see page 13

Schools must offer all four health plans to all employees.

All plans cover the same services—largely the services covered by VEHI plans historically. The variations occur in the plans' payment terms and cost-sharing: each offers different member out-of-pocket arrangements.

The new VEHI plans will continue to have:

- Comprehensive medical coverage in every major benefit category
- A range of cost-sharing options (see the comparison on page 15)
- A calendar-year deductible and cost-sharing (that restarts on January 1)
- The freedom to choose from among BlueCard® network doctors without needing a referral (see "Finding Providers" on page 14)
- The largest, most extensive network of providers within Vermont and the U.S. with over 96 percent of hospitals and 92 percent of health care providers in the U.S. (the percentage is even higher in Vermont)
- Access to doctors and hospitals in more than 200 countries and territories around the world through the BlueCard Worldwide® Program
- The security of the Blue Cross and Blue Shield ID card—the most recognized symbol in health benefits worldwide
- BCBSVT customer service staff available Monday through Friday, 7 a.m. to 6 p.m.
- State-of-the-art wellness programming offered by VEHI PATH and BCBSVT, featuring online tools, face-to-face discussions and much more! (**www.vehi.org**)

What is new?

- All plans now include benefits for certain preventive care at 100 percent of the allowed amount before the deductible—that means no cost to you. Women's health services, such as generic contraceptives, are among those covered by the preventive benefit.
- CDHPs offer a wellness drug benefit, which provides coverage for certain drugs that can help you maintain your health with no cost-sharing.
- All new VEHI plans use our Exclusive Provider Organizations (EPO) network. Our network includes providers in all 50 states and 200 countries and territories worldwide. Ninety-two percent of U.S. providers participate in the network and the percentage is higher in Vermont. You must get all care from **BCBS network** doctors, hospitals and other health care providers or you will **not** receive benefits. (You may request prior approval to go out of network.)
- For all plans, you will choose a **primary care provider** for each family member, but you don't need referrals to see in-network specialists. (You do need prior approval from BCBSVT for certain drugs and services, including any services you receive out of network. Network providers get prior approval for you.)
- All plans have **deductibles** and all have benefits that apply before the deductible, but those benefits may differ between plans (see "Deductible/out-of-pocket limit types" below and the detail charts that follow beginning on page 8).
- Regardless of all other cost-sharing, if your **out-of-pocket** costs reach certain levels, VEHI begins paying 100 percent of the allowed amount.
- VEHI will now include a "parent/child" tier that will cost less than a two-person (two adults) or family plan. A parent can cover any number of children on the plan at no extra cost.
- The Pharmacy program will offer a new, four-tier drug system. For more details on this and other pharmacy changes, see page 5.

Deductible/out-of-pocket limit types

In all of its new plans, VEHI covers certain services only after you have met deductibles, which you pay once in a calendar year. If you have family coverage (any plan other than individual coverage), you may have "aggregate" or "stacked" family deductibles. With a **stacked** deductible, a member on a family plan may meet an individual deductible and begin receiving post-deductible benefits. When the family meets the family deductible, all family members receive post-deductible benefits. With an **aggregate** family deductible, there is no individual deductible. The family must meet the family deductible before any family member receives post-deductible benefits. Out-of-pocket limits (for prescription drugs and for general services) may also be stacked or aggregate.

Consumer-Directed Health Plans

Some VEHI plans are "Consumer-Directed Health Plans" and federal law allows you to pair them with tax-favored **health savings accounts (HSAs)**. A **health reimbursement arrangement (HRA)** can pair with any plan.) VEHI offers integrated financial services to help employers and employees set up accounts. Please see page 10. Contact your employer at the time of enrollment to see if an HRA or HSA is available through your school.

Pharmacy program

As a VEHI member, you will continue to get your prescription drugs through Blue Cross and Blue Shield of Vermont's network of pharmacies (Express Scripts®), here in Vermont and nationwide. Present your ID card at a network pharmacy and the pharmacy will file a claim for you.

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

Your out-of-pocket cost varies depending on the drugs you choose. VEHI's new 4-tier drug program helps keep prescription drug costs down for you and VEHI. For all plans, when a member reaches the out-of-pocket limit of $1,300 for individual coverage or $2,600 for other coverage (parent/child, two-person or family), VEHI will begin to pay 100 percent of the BCBSVT allowed amount.

VEHI Gold and Platium 4-Tier Drug program:

Prescription drug prices are a contributing cause of increases in health care costs and VEHI's health plan premiums. One way to reduce medication costs substantially is to use generic drugs whenever possible. Generics are less expensive than brand-name medications and are just as medically effective. VEHI is among the first BCBSVT groups to offer the cost-saving "4-tier" program. It applies to the VEHI Platinum plan and the VEHI Gold plan, but not to the CDHP plans.

VEHI Gold and Platinum plan members will pay:

- $4 per prescription for Tier 1 (lower-cost) generic drugs
- $10 per prescription for Tier 2 (higher-cost) generic drugs
- $20 per prescription for brand-name drugs that are on BCBSVT's preferred brand-name drug list, or
- 50% coinsurance for non-preferred drugs

The 2-tier generic and preferred brand-name drug lists can change and will be updated periodically to ensure that newer, more effective drugs are added. Drugs automatically come off the preferred brand-name drug list and are added to the generic lists when alternatives become available. You may reduce your out-of-pocket expenses by asking your provider to authorize a generic solution whenever possible. The use of generics guarantees you the lowest cost.

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**.

Please note that the 4-tier drug program will continue to cover medicines for diabetes at 100 percent.

VEHI Gold and Silver CDHP Drug Coverage

CDHP members will pay deductibles and co-insurance for most drug coverage to comply with federal guidelines. Please note that with the VEHI Gold CDHP plan, both the medical deductible and the prescription drug out-of-pocket limit are **aggregate**. With the VEHI Silver CDHP plan, the medical deductible is **stacked**, but the prescription drug out-of-pocket limit is **aggregate**. (See "Deductible/out-of-pocket limit types" on page 4.) To be sure that its members get the important **wellness drugs** they need, VEHI will offer its CDHP members 100 percent coverage on certain drugs that can prevent illness or keep chronic conditions from becoming more serious, for example, prentatal vitamins and many drugs that treat:

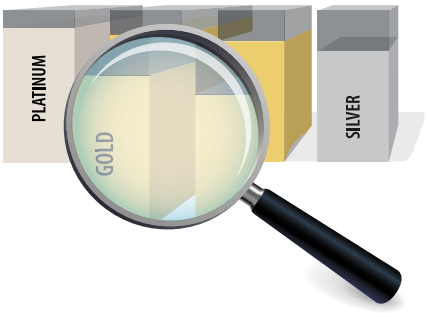
- diabetes
- high blood pressure
- high cholesteral
- asthma
- osteoporosis

The "wellness drug list" changes from time to time. The most recent copy appears on the Rx Center of the BCBSVT website at **www.bcbsvt.com/wellnessrx**.

For all plans

To align more closely with benefit products typically on the market, VEHI will eliminate coverage of drugs for sexual dysfunction and infertility. Please note that services to determine a couple's infertility will still be covered. Also, if you are taking infertility medication prior to January 1, 2018, VEHI will cover the end of your course of treatment under your previous terms of coverage.

compare our plans on page 15



Please note that we summarize all benefit information in this guide. For full details, including restrictions and exclusions, you will need to consult your Summary Plan Description when you enroll in your 2018 coverage.

Preventive care

Blue Cross and Blue Shield of Vermont (BCBSVT) and VEHI want you to get preventive care so you can find out about health problems early and get the treatment you need. Some preventive care can keep you from becoming sick in the first place. This section explains which preventive care is right for you and how we cover various services.

What is preventive care?

Preventive care includes screenings, tests, medicines and counseling performed or prescribed by your doctor or other health care provider when you don't have signs or symptoms of an injury or illness. Your provider delivers some care to prevent you from getting sick. Other preventive care helps detect health conditions early, so you can change your lifestyle or get treatment to improve your health. We encourage you to get appropriate preventive care for your age and gender.

What will preventive care cost me?

VEHI covers certain preventive services at no cost to you (i.e., with no "cost-sharing" like deductibles, co-insurance or co-payments). We provide this benefit for all services rated A or B* by the United States Preventive Services Task Force (USPSTF), a board of physicians who have researched preventive services to determine which are the most effective. We also cover certain women's health services, vaccines, care for children without cost-sharing.

You *do* have to pay cost-sharing for other preventive services.

What is the difference between preventive and diagnostic medicine?

A preventive procedure starts with the intent of confirming your good health when you are seemingly free of symptoms or disease. Diagnostic medicine happens when you go to your doctor or other health care provider with symptoms and your provider recommends screenings and tests to diagnose their cause. While we cover diagnostic services, you may have to pay deductibles, co-payments and/or co-insurance.

Can preventive care turn into diagnostic medicine?

Yes. Sometimes a provider begins a preventive screening or test and, during its course, finds or suspects disease. The provider then bills for a diagnostic procedure. You may have to share in the cost. Also, if you have a history of a particular illness, a screening related to that illness might be considered diagnostic for you, while it may be preventive for other patients.

Check out these examples:

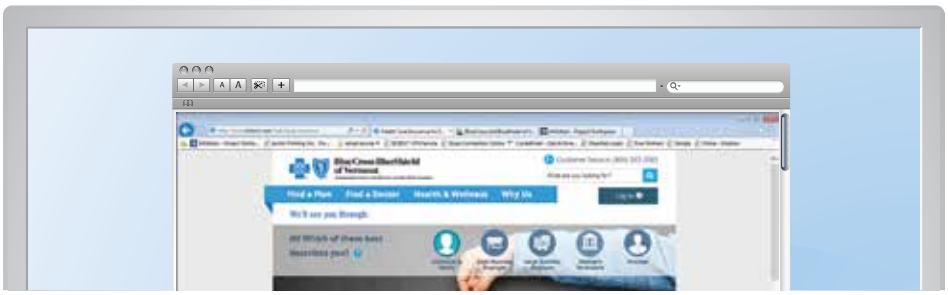
Scenario 1: A 30-year-old woman without symptoms has an annual physical. It includes a breast exam, a Pap smear, cholesterol and glucose screening and screening for sexually transmitted diseases. The Pap smear shows an irregularity. The first exam will be paid at the preventive level. A follow-up exam, done at a later date because of the irregularity of the Pap, will be paid subject to cost-sharing.

Scenario 2: You have a lipid test and a metabolic panel (a blood test that measures your glucose level, electrolyte and fluid balance and kidney and liver function) at your annual physical. You do not have cost-sharing for the lipid test, but since the metabolic panel does not appear on the USPSTF's list of A- and B-rated services, you must share in the cost of the metabolic test.

Are there other preventive services that I may need?

Yes, you may need other preventive services because of your individual health care needs. The USPSTF bases its recommendations on the needs of the general population. You may have special needs, so we encourage you to consult your doctor or other health care provider about additional preventive care. You may have cost-sharing if you have such services.

For a more detailed description of preventive care, including charts that list care rated A or B by the USPSTF, visit www.bcbsvt.com/preventive



Web resources

On the public section of Blue Cross and Blue Shield of Vermont's website, you can:

- Watch videos on important health topics
- Find a network health care provider or change your primary care provider
- Find information about past, current and future community events, which often offer you free access to parks and other venues

The Member Resource Center

Log on to BCBSVT's online Member Resource Center and you can find information about your health plan whenever you need it. The benefit description portion of your summary plan description (SPD) and all other documents that apply to your plan are on our site and ready for you when you log on to our Member Resource Center at **www.bcbsvt.com/MRC**.

You may also use the Member Resource Center to:

- Check claims status
- Change your address
- View benefit information, like deductibles and co-payments for various services
- Print a temporary ID card or request a new ID card
- Print a proof of coverage
- E-mail Blue Cross and Blue Shield of Vermont a secure message
- Track your charges and what you've paid out of pocket
- Research the cost of in-network medical services and supplies, find doctors and compare hospitals with our price and quality tools
- Research thousands of health topics, including information on prescription and non-prescription drugs, on the Healthwise Knowledge Center
- On the online health database, find an e-symptom checker and other interactive tools to help manage your health

VEHI PATH Wellness Program

Learn more about your VEHI PATH benefits at **www.vehi.org**. Enjoy a vast array of programming to help you live your best life. Be a part of a great community, achieve healthy goals and earn points toward fun prizes:

- Complete the health assessment to know where you stand and where you're headed
- Track your routine in the PATH Community using the Keeping Fit tool
- Work with a professional coach or EAP counselor for specific, in-depth goals
- Join the PATH Adventure, state-wide wellness challenge each winter and much more

Pharmacy Resource Center—

From BCBSVT's robust pharmacy resource center, you will be able to:

- **Price a drug**—Compare the cost of a medication at your local pharmacy vs. the price of home delivery, or the drug prices between pharmacies.
- **Locate a pharmacy**—Easily locate a pharmacy near you or across the country. Each listing includes the pharmacy's phone number and MapQuest® directions.
- **Order prescriptions**—Quickly refill home delivery prescriptions online, and check the status of your orders. Email alerts keep you informed as your prescription is filled and shipped to you.
- **View pharmacy benefit information**—View your pharmacy benefits and review your prescription claims history.
- **Access doctor-visit kit**—Print out a personalized kit that details your prescription history and is designed to help encourage dialogue between you and your doctor.

HRA/HSA Resources

To learn about health care spending accounts through articles and videos, visit **www.healthequity.com/learn**.

Help us go green. Get your EOB online!

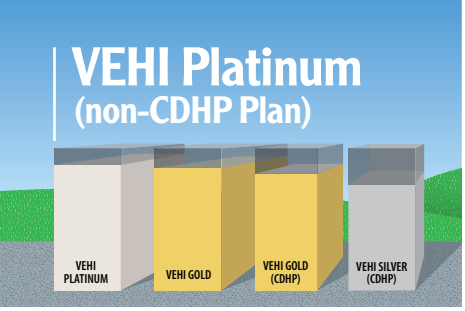
Trying to reduce the amount of paper that comes into your home? You can now get your Explanation of Benefits (EOB) documents on our member resource center. You can also choose to get notifications about EOBs via email or text messages. To opt into this planet-friendly option:

- Visit **www.bcbsvt.com/mrc**, then log in or "Register."
- In the left-hand navigational pane, you will find the "Go Green" button, which you can use to let us know that you will forego paper EOBs.
- Select whether you want online delivery only or whether you want email or text message notifications.
- You can then log in to the member resource center at any time to see copies of your EOBs from the last 18 months.

You may also call the BCBSVT customer service team at (800) 247-2583 and opt in to online EOB delivery.

Please note that each member age 12 or older must opt out of paper delivery separately. For privacy protection, members age 12 or older see only their services on their paper or online EOBs. The subscriber (the member whose name is on the membership) sees his or her services and those of members under age 12.

VEHI Platinum (non-CDHP Plan)



Compatible with an HRA

General cost-sharing (applies to some services before your plan provides benefits)

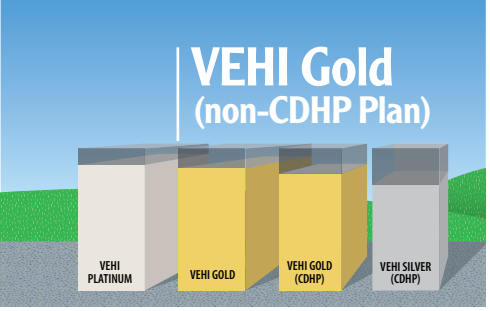
Deductible (stacked)
- $500 individual
- $1,000 family*

Out-of-pocket limit (stacked)
- $1,500 individual
- $3,000 family*

*This plan employs **stacked deductibles and out-of-pocket limits**. Each individual in your family need only meet the individual deductible each year before VEHI begins paying benefits. When your entire family's expenses combined meet the family deductible, VEHI begins paying benefits for all family members. When an individual meets the individual out-of-pocket limit, VEHI pays 100% of our allowed amount for that member for the rest of the calendar year. When the family meets the family out-of-pocket limit, VEHI pays 100% for all covered expenses for all family members for the rest of the year.*

(NETWORK PROVIDERS ONLY)	YOU PAY	VEHI PAYS
OUTPATIENT CARE		
preventive care *(see page 6)* Includes well baby, adult preventive, gynecological preventive office visits; includes preventive services such as laboratory, screening mammograms, Pap tests and colonoscopies. Excludes diagnostic services.	No member cost	100% of the allowed amount
primary care provider office visits	$25 co-payment	All but your co-payment
mental health and substance abuse office visits	$25 co-payment	All but your co-payment
specialist office visits may require prior approval	$35 co-payment	All but your co-payment
maternity office visits	One $25 co-payment for all prenatal and post-partum care from one provider	All but your co-payment
chiropractic care prior approval required after 12 visits per year	$35 co-payment	All but your co-payment
diagnostic services includes labs, X-ray, etc.; may require prior approval	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100%.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
outpatient surgery prior approval may be required		
outpatient physical, occupational and speech therapy up to 30 visits combined per calendar year		
urgent care at an urgent care facility	$75 co-payment	All but your co-payment
emergency care	$250 co-payment (waived if admitted)	All but your co-payment
INPATIENT CARE		
inpatient care, general hospital Includes maternity, newborn care, mental health and substance abuse.	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
HOME CARE AND REHABILITATION SERVICES		
inpatient skilled nursing or rehabilitation prior approval required for rehabilitation	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
home health and hospice care services prior approval required		
private duty nursing up to 14 hours per member per calendar year		
OTHER SERVICES		
ambulance prior approval required for non-emergency transport	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
medical equipment and supplies prior approval may be required		
vision exam one exam per year	$20 per exam	All but your co-payment
PRESCRIPTION DRUGS		
prescription drugs (including home delivery) prior approval may be required	Your cost-sharing: ▪ $4 co-payment for generics on Tier 1 (lower-cost generics) ▪ $10 co-payment for generics on Tier 2 (higher-cost generics) ▪ $20 co-payment for preferred brand-name drugs ▪ 50% co-insurance for non-preferred brand-name drugs. Your prescription costs are limited to $1,300 each year if you have an individual plan or $2,600 each year if you have a family plan.	All but your co-insurance and co-payments at left. VEHI pays 100% of the allowed amount if you meet your prescription drug out-of-pocket limit of $1,300 for a single plan or $2,600 for a two-person, parent/child or family plan. This is a stacked out-of-pocket limit.

*A family plan is defined as a two-person, parent/child or family membership.



Compatible with an HRA

General cost-sharing (applies to some services before your plan provides benefits)

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- $2,400 family*

Out-of-pocket limit (stacked)
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- $3,600 family*

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maternity office visits	One $25 co-payment for all prenatal and post-partum care from one provider	All but your co-payment
chiropractic care prior approval required after 12 visits per year	$35 co-payment	All but your co-payment
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medical equipment and supplies prior approval may be required		
vision exam one exam per year	$20 per exam	All but your co-payment
PRESCRIPTION DRUGS		
prescription drugs (including home delivery) prior approval may be required	Your cost-sharing: ▪ $4 co-payment for generics on Tier 1 (lower-cost generics) ▪ $10 co-payment for generics on Tier 2 (higher-cost generics) ▪ $20 co-payment for preferred brand-name drugs ▪ 50% co-insurance for non-preferred brand-name drugs. Your prescription costs are limited to $1,300 each year if you have an individual plan or $2,600 each year if you have a family plan.	All but your co-insurance and co-payments at left. VEHI pays 100% of the allowed amount if you meet your prescription drug out-of-pocket limit of $1,300 for a single plan or $2,600 for a two-person or family plan. This is a stacked out-of-pocket limit.

*A family plan is defined as a two-person, parent/child or family membership.

CDHPs (compatible with HSAs or HRAs)

VEHI's health plans can be integrated with tax-advantaged spending accounts to cover the costs of qualified medical expenses. This section provides introductory explanations of:

- Consumer-Directed Health Plans (see pages 12-13 for VEHI's CDHP offerings)
- Qualified health care expenses
- Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs).

You can find more detailed information on the VEHI website.

What is a CDHP?

A CDHP is a consumer-directed health plan (sometimes referred to as a consumer-driven health plan). VEHI uses the term CDHP for its health plans that can be paired with health savings accounts (HSAs).* VEHI's CDHP plans also pair with Health Reimbursement Arrangements (as do all health plans); however, VEHI's non-CDHP plans may not, under federal law, be paired with HSAs.

In order to be paired with an HSA in conformance with tax law, a health plan's deductible must be at least $1,300 for an individual plan or $2,600 for a two-person or family plan in 2017. Two of VEHI's plans—Gold CDHP and Silver CDHP—meet this criteria.

**Please note that Blue Cross and Blue Shield of Vermont offers non-VEHI plans that are called CDHPs, but do not meet the criteria to be paired with HSAs. Both VEHI CDHPs do, however.*

About HealthEquity®: a national leader in health care spending accounts

VEHI and BCBSVT have partnered with HealthEquity, a national expert in administering health care spending accounts. HealthEquity offers integrated HRA and/or HSA services.

If HealthEquity administers your account, you can count on:

- Claims processing integrated with HSA or HRA reimbursement, reducing paperwork and speeding reimbursement to members
- An optional debit card that will only allow purchases of "qualified" services or supplies (see page 11)
- Useful tools that help members manage their accounts, such as a mobile app.

For more information on HealthEquity and the other services they provide, go to: **www.healthequity.com**.

What are Health Reimbursement Arrangements (HRAs)?

HRAs are tax-favored accounts from which employees may draw employer-sponsored funds to cover qualified medical expenses. An HRA is set up and funded only by an employer with support, generally, from a Third Party Administrator such as HealthEquity. Employers that offer HRAs must develop plan documents stating for which "qualified medical expenses" (see sidebar on page 11) their employees may use HRA funds.

Employers and local unions can decide which qualified services HRA funds can cover. A plan document may be structured to permit the use of HRA funds to cover all or some portion of deductibles, co-payments and/or co-insurance expenses. If an employer's plan document allows it, employees may also use HRA funds to pay for costs considered qualified medical expenses by the IRS, but not covered by a health plan. When employees use HRA funds for these expenses, they must complete paper claim forms to get reimbursement from the HRA administrator, as these claims are not integrated through the BCBSVT claims feed.

Funds not used by employees in a calendar year generally remain with the employer. Employers may opt to allow funds to carry over from year to year. When an employee leaves employment, HRA funds stay with the employer. Note however that employees can keep their HRAs if they elect coverage under federal COBRA continuation of coverage requirements. Employers must then continue to make contributions equal to those they make for similarly situated active employees.

All four VEHI plans may be paired with HRAs. Contact you employer at the time of enrollment to see if an HRA is available through your school.

What are Health Savings Accounts (HSAs)?

An HSA is also a tax-favored healthcare spending account, and will be available to school employees who are enrolled in the VEHI Gold CDHP or the VEHI Silver CDHP. Employees may draw funds from their HSAs to cover costs of qualified services, including deductibles, co-insurance and other costs considered "qualified medical expenses" by the IRS, but not covered by a health plan (see the sidebar on page 11).

Federal tax laws determine the criteria for which health plans can be paired with HSAs. The deductible must be at least $1,300 for an individual plan or $2,600 for a two-person or family plan in 2017, for example.

HSAs are set up by employees and can be funded by the employee or by both employees and employers. The IRS limits the amount that may be contributed to an HSA each year, and that amount may be increased periodically by the federal government. In 2017, employees with individual coverage will be able to contribute up to $3,400. Individuals with two-person, parent/child or family coverage can contribute up to $6,750. Individuals between 55 and 65 years of age may contribute an additional $1,000. Once individuals reach the age of 65, they may not contribute.

If an employer contributes on behalf of an employee, the amount the employee may contribute is reduced by the amount the employer puts in the account. Employer contributions are considered as employer-provided coverage and the employer may exclude them from the employee's gross

income. Employers and their employees may make contributions in one or more payments.

The funds in an HSA, even those contributed by an employer, belong to an employee, even if the employee doesn't use them in the current calendar year, or if the employee leaves employment.

Employees can save money tax-free for health care costs, and roll those unused funds over year after year. Financial gains come from coupling tax-free earnings with smart purchasing decisions, like using lower-cost generic drugs. The HSA acts like a 401(k) for health care. You can save for medical expenses throughout your life. You can even use HSA funds to pay for Medicare premiums after you turn 65.

Employees may select any financial institution that offers the service to set up and manage an HSA. As noted above, VEHI and BCBSVT can help, thanks to a relationship with HealthEquity.

It is important to know the expenses for which you may use your tax-favored HSA. (See "What are 'qualified medical expenses'?" at the right.) The penalty for using HSA funds for non-qualified expenses is 20 percent, plus the loss of tax-free treatment for the distribution, if you are under age 65. Keep all itemized receipts and copies of prescriptions for over-the-counter medications in case of an IRS audit. HealthEquity provides the ability to keep electronic receipts online.

HSA Considerations

HSAs are not for everyone. Generally, an HSA might not be allowed for:

- An employee who has other coverage, through a spouse, for example. Employees who have other coverage are ineligible for HSAs.
- An employee who is over age 65, since he or she would not be eligible to contribute to an HSA.

While federal health care reform allows parents to cover their adult children up to age 26, parents can only use money from their HSAs for children they can claim as **dependents** on their tax returns (generally, those under age 18 or in school full time). Note, however, that dependent children between the ages of 18 and 26 are eligible to set up HSAs on their own and contribute up to the federal limits.

What are "qualified medical expenses"?

The IRS determines expenses for which you may use tax-favored accounts. They are called "qualified medical expenses." They include medical, dental, vision and prescription expenses. IRS publication 502 (www.irs.gov/publications/p502/) provides an exhaustive list. Here are examples:

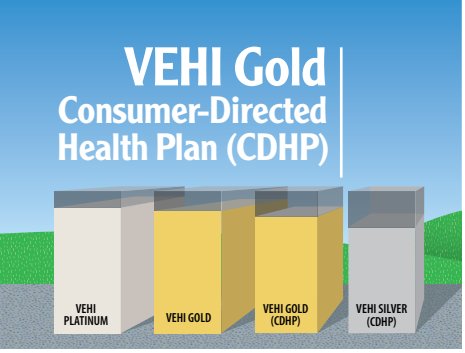
- Cost-sharing you must pay when your health plan provides benefits, such as:
  - Deductibles
  - Co-insurance
  - Co-payments
- Expenses for services that may not be covered by your health plan, such as:
  - Acupuncture
  - Contact lenses
  - Dental treatments
  - Hearing aids
  - Over-the-counter medicines (only with a prescription)
  - Orthodontia
  - Tobacco cessation therapy
  - Telephone equipment for the hearing-impaired
  - Weight-loss program (as prescribed)
  - Wigs (as prescribed)

Examples of services that are <u>not</u> qualified medical expenses include:

- Concierge services
- Dancing lessons
- Diaper service
- Elective cosmetic surgery
- Electrolysis or hair removal
- Funeral expenses
- Hair transplants
- Health club dues
- Insurance premiums (except long-term care premiums or Medicare Part A, B or D premiums paid by individuals over age 65)

The IRS does not allow HSA funds to be used for over-the-counter (OTC) medicines without a prescription. You may want to ask your doctor if he or she can write a prescription for OTC medicines or supplies that you use frequently. Then you can use your HSA to pay for these items.

VEHI Gold Consumer-Directed Health Plan (CDHP)



Compatible with HRAs and HSAs

General cost-sharing (applies to most services before your plan provides benefits)

Deductible (aggregate)

- $1,800 if you have individual coverage
- $3,600 if you have a family* plan

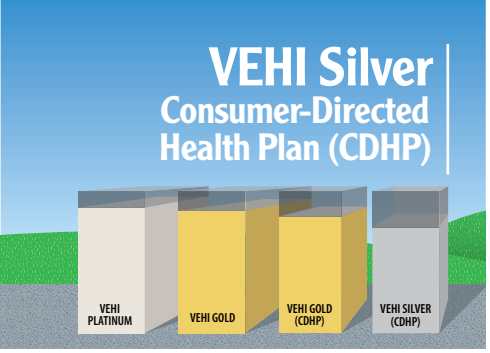
Out-of-pocket limit (aggregate)

- $2,500 if you have individual coverage
- $5,000 if you have a family* plan

*This plan employs an **aggregate deductible and out-of-pocket limit (including your prescription out-of-pocket limit)**. If you have a family* plan, your family members' expenses combined must meet the entire $3,600 family deductible each year before VEHI begins paying benefits for most services. When your entire family's expenses combined meet the $5,000 out-of-pocket limit, VEHI pays 100% of our allowed amount for all covered expenses for the rest of the year. Prescription drugs have a lower out-of-pocket limit. See below.*

(NETWORK PROVIDERS ONLY)	YOU PAY	VEHI PAYS
OUTPATIENT CARE		
preventive care (see page 6) Includes well baby, adult preventive, gynecological preventive office visits; includes preventive services such as laboratory, screening mammograms, Pap tests and colonoscopies. Excludes diagnostic services.	No member cost	100% of the allowed amount
primary care provider office visits	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
mental health and substance abuse office visits		
specialist office visits may require prior approval		
maternity office visits		
chiropractic care prior approval required after 12 visits per year		
diagnostic services includes labs, X-ray, etc.; may require prior approval		
outpatient surgery prior approval may be required		
outpatient physical, occupational and speech therapy up to 30 visits combined per calendar year		
emergency and urgent care		
INPATIENT CARE		
inpatient care, general hospital Includes maternity, newborn care, mental health and substance abuse.	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
HOME CARE AND REHABILITATION SERVICES		
inpatient skilled nursing or rehabilitation prior approval required for rehabilitation	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
home health and hospice care services prior approval required		
private duty nursing up to 14 hours per member per calendar year		
OTHER SERVICES		
ambulance prior approval required for non-emergency transport	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
medical equipment and supplies prior approval may be required		
vision exam one exam per year	$20 per exam	All but your co-payment
PRESCRIPTION DRUGS		
prescription drugs (including home delivery) prior approval may be required	Deductible, then 20% co-insurance until you meet your prescription drug out-of-pocket limit of $1,300 for a single plan or $2,600 for other coverage. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit of $1,300 for a single plan or $2,600 for other coverage. After that, VEHI pays 100% of the allowed amount for the rest of the year. This is an aggregate out-of-pocket limit.
wellness drugs Visit **www.bcbsvt.com/wellnessrx** to find a list.	For certain drugs that prevent or treat a chronic illness, you do not have to pay your deductible or co-insurance. VEHI covers those drugs at 100% of the allowed amount.	100% of the allowed amount.

*A family plan is defined as a two-person, parent/child or family membership.



Compatible with HRAs and HSAs

General cost-sharing (applies to most services before your plan provides benefits)

Deductible (stacked)
- $3,000 individual
- $6,000 family*

Out-of-pocket limit (stacked)
- $4,000 individual
- $8,000 family*

*This plans employs **stacked deductibles and out-of-pocket limits**. Each individual in your family need only meet the individual deductible each year before VEHI begins paying benefits. When your entire family's expenses combined meet the family deductible, we begin paying benefits for all family members. When an individual meets the individual out-of-pocket limit, VEHI pays 100% of our allowed amount for that member for the rest of the calendar year. When the family meets the family out-of-pocket limit, VEHI pays 100% for all covered expenses for the rest of the year. Prescription drugs have a lower out-of-pocket limit, but it is **aggregate**. If you have a family plan, the entire family's expenses must meet the $2,600 out-of-pocket limit; then VEHI will pay 100% of our allowed amount for your drugs. See below.*

(NETWORK PROVIDERS ONLY)	YOU PAY	VEHI PAYS
OUTPATIENT CARE		
preventive care (see page 6) Includes well baby, adult preventive, gynecological preventive office visits; includes preventive services such as laboratory, screening mammograms, Pap tests and colonoscopies. Excludes diagnostic services.	No member cost	100% of the allowed amount
primary care provider office visits	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
mental health and substance abuse office visits		
specialist office visits may require prior approval		
maternity office visits		
chiropractic care prior approval required after 12 visits per year		
diagnostic services includes labs, X-ray, etc.; may require prior approval		
outpatient surgery prior approval may be required		
outpatient physical, occupational and speech therapy up to 30 visits combined per calendar year		
emergency and urgent care		
INPATIENT CARE		
inpatient care, general hospital Includes maternity, newborn care, mental health and substance abuse.	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
HOME CARE AND REHABILITATION SERVICES		
inpatient skilled nursing or rehabilitation prior approval required for rehabilitation	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
home health and hospice care services prior approval required		
private duty nursing up to 14 hours per member per calendar year		
OTHER SERVICES		
ambulance prior approval required for non-emergency transport	Deductible, then 20% co-insurance until you meet your out-of-pocket limit. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit (above). After that, VEHI pays 100% of the allowed amount for the rest of the year.
medical equipment and supplies prior approval may be required		
vision exam one exam per year	$20 per exam	All but your co-payment
PRESCRIPTION DRUGS		
prescription drugs (including home delivery) prior approval may be required	Deductible, then 20% co-insurance until you meet your prescription drug out-of-pocket limit of $1,300 for a single plan or $2,600 for family coverage. After that, VEHI pays 100% of the allowed amount for the rest of the year.	80% after deductible until you meet your out-of-pocket limit of $1,300 for a single plan or $2,600 for family coverage. After that, VEHI pays 100% of the allowed amount for the rest of the year. This is an aggregate out-of-pocket limit.
wellness drugs Visit **www.bcbsvt.com/wellnessrx** to find a list.	For certain drugs that prevent or treat a chronic illness, you do not have to pay your deductible or co-insurance. VEHI covers those drugs at 100% of the allowed amount.	100% of the allowed amount.

*A family plan is defined as a two-person, parent/child or family membership.

Choosing providers

Finding a doctor in the EPO network

The most up-to-date information about our provider network appears online. To find out if a provider is in our network:

- Visit **www.bcbsvt.com**.
- Select "Find a Doctor" from the blue band at the top.
- To find a doctor or hospital in Vermont or the surrounding area, select "Providers and Hospitals." See at right on how to find an out-of-state provider.
- You may search by name or by provider type.
- 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, for example, or look for providers of a certain gender or those who speak a certain language.

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.

Selecting a primary care provider (PCP)

You must select a primary care provider for each covered family member in order to enroll. To do this:

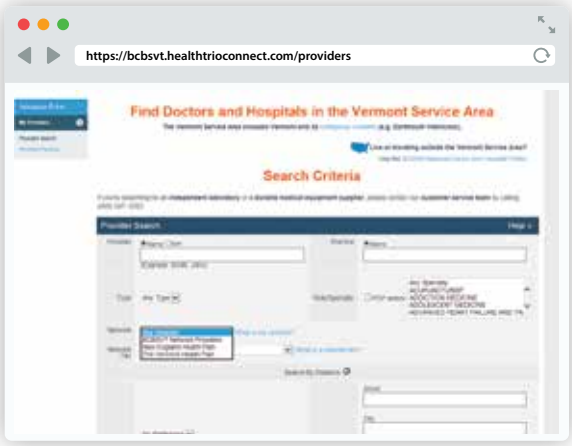
- Follow the steps above to find a doctor online and check the PCP box in the "Role/Specialty" section.
- If you are not currently seeing a primary care provider, be sure to check the "Accepting New Patients" box at the bottom of the form.
- If you are currently seeing a primary care provider, he or she may not be taking new patients. Be sure to check the "Existing patient" box on your enrollment form when you enroll.
- Use the provider name and National Provider Identification (NPI) number from your search results to complete your enrollment form.

How to find a provider outside of Vermont

Go to: **www.bcbsvt.com**

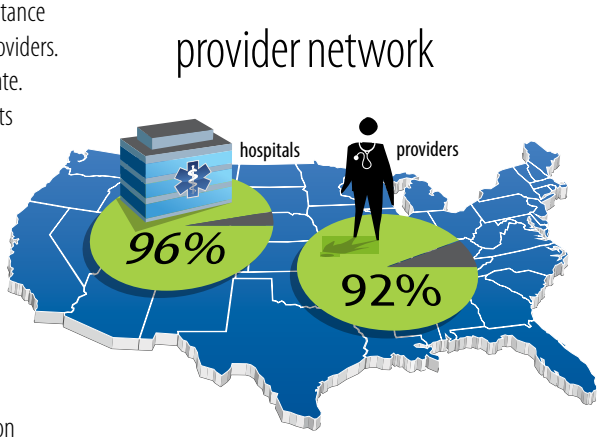
- From the home page, select "Find a doctor"
- Select "Provider or Hospital Finder" and then "BCBSA National Doctor and Hospital Finder." This will now bring you to the Blue Cross Association's finder tool
  - Type in the first three letters in front of your member number from your ID card (VEH, beginning in 2018)
  - Enter the type of provider you are looking for *OR*
  - Select "Add a filter"
  - From the letters of the alphabet, select the provider type(s) you are searching for
  - Add your location and zip code
  - Select "Search"

When the results appear you can select "Create a Directory" and either print the results or save them to your computer.



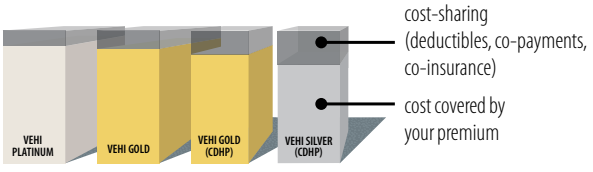
For BlueCard, networks are of critical importance in determining reimbursement levels to providers. VEHI plans will use PPO networks out of state. A Blue Plan's PPO network and the discounts it negotiates with PPO providers can be completely different than the same Plan's traditional network and the discounts that apply there. Your three-digit alpha prefix tells other Blue Plans how to price claims from providers in various networks. Use the National Doctor Hospital Finder prefix field to receive valid, accurate information on an individual provider. If the provider is in your network and you've entered your prefix, the search will return your provider's information.

We encourage you to use our National Doctor Hospital Finder, and not rely on out-of-state providers to advise you of whether or not they are in your network.



VEHI 2018 Plans Comparison *Effective January 1, 2018*

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



* CDHP–Consumer Directed Health Plan

^ stacked–See definition at right.

** aggregate–See definition at right.

\# wellness drugs–**www.bcbsvt.com/wellnessrx**

Deductible/out-of-pocket limit types

In all of its new plans, VEHI covers certain services only after you have met deductibles, which you pay once in a calendar year. If you have family coverage (defined as two-person, parent/child or family coverage), you may have "aggregate" or "stacked" family deductibles. With a **stacked** deductible, a member on a family plan may meet an individual deductible and begin receiving post-deductible benefits. When the family meets the family deductible, all family members receive post-deductible benefits. With an **aggregate** family deductible, there is no individual deductible. The family must meet the family deductible before any family member receives post-deductible benefits. Out-of-pocket limits may also be stacked or aggregate.

Contact BCBSVT or VEHI

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

Mail

Blue Cross and Blue Shield of Vermont

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

Vermont Education Health Initiative

52 Pike Drive
Berlin, VT 05602

Phone

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

Websites

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

Vermont Education Health Initiative:
www.vehi.org

Pharmacy Network:
www.express-scripts.com

HSA/HRA information
www.healthequity.com/learn

In person

Blue Cross and Blue Shield of Vermont

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

vehi

Vehi2018@vsbit.org

VEHI's health benefit plans are administered by:

BlueCross BlueShield of Vermont

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

P.O. Box 186
Montpelier, VT 05601-0186
Phone: (800) 247-2583
Email: customerservice@bcbsvt.com

www.bcbsvt.com

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