Enrollment Guide
for Employers and Employees in Qualified Health Plans
2017 Benefits Program

We’ll see you through.

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.
We have created this guide for employers who purchase Qualified Health Plans and their employees. In it, you’ll find:

- Information on how to enroll using our easy-to-use Web tools (page 4)
- A comparison chart showing all of our Qualified Health Plans (pages 10-11)
- Information on our Blue Rewards Health and Wellness ProgramSM (page 12)
- Detail about our Blue Rewards Gold and Silver plans (page 13)
- Information about Consumer-Directed Health Plans or CDHPs (page 14)
- Details on the state-designed (standard) CDHP plans (page 16)
- Details on our Blue Rewards CDHP plans (page 17)
- Details on the state-designed (standard) non-CDHP Platinum, Gold, Silver and Bronze plans (pages 18-19)
- An explanation of preventive care and how to get it without cost-sharing (page 20)
- Information about our pharmacy programs and how to save money on drugs (page 22)
- Detail on how our Blue Health SolutionsSM integrated health support programs can help members stay healthy, feel better or deal with chronic or serious illness (pages 24-25)
- Notices about member rights and other important information required by law (pages 26-28)

We encourage you to read this guide to learn more about our health plans now, as you make selections and/or enroll. We believe getting information early will help you make the most of your benefits.
What’s new in 2017 — and how it affects your health coverage

The health care landscape changes every year. As we get ready for 2017, here is a quick list of some of the changes that affect your coverage in the coming year:

- In response to legislation passed in 2016, members can receive up to a **12-month supply of prescription contraceptives** at a time, and certain plans cover sterilization with no cost-sharing.

- The list of special enrollment periods (SEPs) now includes **pregnancy**, so new members who find out they are pregnant\(^1\) can enroll in coverage outside of open enrollment.

- Blue Cross and Blue Shield of Vermont offers a **new online cost and transparency tool** that helps members compare the bundled costs for over 1,600 treatment categories at 20,000 health care facilities and 400,000 professional providers across the U.S. Members can also calculate their out-of-pocket costs based on their current benefits in real time.

- Our **Blue Rewards Bronze CDHP plan is no longer HSA-compatible**; for 2017 we offer one Blue Rewards CDHP and two standard plans that are HSA-compatible High Deductible Health Plans (see page 17).

- We have made changes to our **Blue Rewards program** to offer groups and individuals **new features** (see page 12).

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Costs of health care

More than 90 percent of your premium goes directly toward the cost of paying for care. BCBSVT uses just 6.9 percent to process your claims, provide wellness programs and incentives and deliver services like integrated health management services and our world-class customer call center. You’ll notice in the model at right that 2 percent of your premium goes toward “reserve.” This is like a savings account that BCBSVT can use to pay claims in the case of extremely high health care use —— for example, during a disaster.

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\(^1\) New enrollees and adds only (no plan changes allowed). Pregnant person must enroll in coverage, or qualifying household members may also enroll any time during pregnancy up to date of birth.
Employers:

If you own or manage a business with up to 100 employees you can purchase your qualified health plan (QHP) directly from a health plan like Blue Cross and Blue Shield of Vermont. Our team will make sure that your coverage will meet requirements of the Affordable Care Act and state law. You can offer employees their choice of qualified health plans or offer only one plan.

We have tools to make enrolling your employees simple and easy.

1. If your group currently has a QHP, decide whether you want to keep the same plan or plans you had last year. If you do, you don’t need to do anything at all.

2. If you’re new to QHPs or you want to change plans or offer your employees more choice, make your changes in one of the following ways:

   Log on to our Employer Resource Center where you will find a tool when open enrollment begins. If you are an employer of 100 or fewer employees, you will see a “2017 renewal” button on your group detail page. You can make changes to plan selections. You may also add or remove employees and dependents as applicable. Once you have finished all changes, type your name to authorize your renewal. While you may save changes as you go, once you authorize the renewal, you will not be able to make changes via the tool. (Call our exchange consultants to make subsequent changes.)

   OR

   If you are not familiar with our Employer Resource Center, you may:
   - Call our consumer and business support team at (800) 255-4550 and our consultants will make changes for you.
   - Use our secure form to give us information. Find it at www.bcbsvt.com/directenroll.

Please note that the only way to use our pre-populated data is to use the employer resource center tool.
Employees:

Our Find-a-Plan tool includes a feature by which you can enter your employer’s contribution amount. If your employer offers a choice of plan, you can compare and model plans with that contribution amount calculated in your premium.

Enter Employer’s Monthly Contribution($):

I don’t know…
Once you find out from your employer, come back and see how it changes your monthly premium. In the meanwhile, we can show you what plans best meet your needs!

Did you know?
In all of our plans, we cover your annual physical exam and most (or all) of the preventive labs associated with it at 100 percent of the allowed amount, before the deductible.
Our website is your home for everything related to Blue Cross and Blue Shield of Vermont. Our site features easy access to information on your health plan, up-to-date news on our company and info on any upcoming events. Our site also includes a secure location for you to access your personal plan information, an easy-to-use prescription drug information tool and a searchable database of all providers within our network.

Member Resource Center

We’ve designed our Member Resource Center as a user-friendly site that gives you access to information on your health plan. You can view your benefit information, such as deductibles and co-payments, and check the status of your claims. You can also:

- Read your subscriber contract documents
- Change your address (please be sure also to change this with your employer)
- Change your primary care provider
- Order a new ID card
- Print a proof of coverage
- View your Explanation of Benefits documents for the last 18 months (see green box on page 7)
- Email Blue Cross and Blue Shield of Vermont a secure message
- View our newsletters in PDF (Acrobat) file format or save them to read from your computer at your leisure
- Use our enhanced National Doctor and Hospital Finder to compare the bundled costs of health services at provider hospitals
- Research cost and quality of in-network and out-of-network services and much more!

To gain entry to the member portal, visit www.bcbsvt.com/member, then follow the prompts to either log in or register as a new user.

Pharmacy Resource Center

From our robust pharmacy resource center, you can:

- **Price a Drug**—compare the cost of a medication at your local pharmacy vs. the price of home delivery, or compare 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 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 our doctor visit kit**—print out a personalized kit that details your prescription history and can help you start a dialogue with your doctor

To check out our Pharmacy portal, visit www.bcbsvt.com/RxCenter.

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**Did you know?**

With our 3–6–9 plans, you can visit your primary care provider or your mental health provider and receive care at no cost to you before you meet your deductible.
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:

- 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 in Vermont Service Area.” See the column on the 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 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

You must use PPO/EPO networks out of state. Use the National Doctor Hospital Finder to find doctors, hospitals and other providers in that 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.

To use the tool, go to: www.bcbsvt.com

- From the home page, select “Find a Doctor”.
- Select “National and International Providers and Hospitals” and then scroll down to “Locate Participating Doctors & Hospitals.” This will 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 (your three-digit alpha prefix will signify that you want to find providers in the PPO/EPO network).
  - Enter the type of provider you are looking for.
  - Add your location.
  - Select “Search”.

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

Help us go green.
Get your EOB online!

Trying to reduce the amount of paper that comes into your home? You can 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 and log in or “Register.”
- Look for 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 our customer service team at (800) 247-2583 and opt into 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.
Some ways all of our plans are alike:

- You choose a **primary care provider** for each family member, but you don’t need referrals to see in-network specialists.
- You must get all care from network doctors, hospitals and other health care providers or you won’t receive benefits. But our network includes providers in all 50 states and 200 countries and territories worldwide. More than 90 percent of U.S. providers participate in the network and the percentage is even higher in Vermont.
- All plans have **deductibles** and all have benefits that apply before the deductible, but those benefits may differ between plans (See the detail charts on pages 10-11.)
- Certain **preventive care** is covered at 100 percent before the deductible in all plans.
- Regardless of all other cost-sharing, if one individual’s **out-of-pocket costs** reach $7,150 in a year, we begin paying 100 percent of the allowed amount for that person’s covered services and supplies.

Some ways the plans differ:

- **3-6-9 benefits** allow coverage at 100 percent of our allowed amount for a certain number of visits with primary care providers or mental health professionals before you meet deductibles. You get three if you have a single plan, six visits (combined) with a two-person plan or nine visits with a family plan. (See page 13.)
- **Deductible types**—In many plans, you get coverage for most services only after you have met deductibles, which you pay once in a calendar year. You may have “stacked” or “aggregate” family deductibles. With a **stacked** deductible, a member on a two-person or 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** deductible, the two-person or family plan members must meet the family deductible before any family member receives post-deductible benefits.
- Some plans are “**High Deductible Health Plans (HDHP)**” and federal law allows members to pair many of them with tax-favored **health savings accounts (HSAs)**. An employer may pair a **health reimbursement arrangement (HRA)** with any plan. We offer integrated financial services to help you set up accounts.
Vision and dental benefits for children:

In all plans, members up to age 21 have benefits for dental services. Some of these services do not require cost-sharing. (See the benefit charts later in this booklet.) For reference:

- Class I services generally include exams, cleanings, X-rays and diagnosis.
- Class II services include fillings, crowns and jackets, repair of crowns, extractions and root canals.
- Class III services include dentures and bridges (or replacement of same) and medically necessary orthodontia.

Members up to age 21 also have certain benefits for vision exams and vision materials like glasses and contact lenses (see the note at right about vision services.)

Did you know?

The Green Mountain Care Board reviews and approves all of our products and rates for employers of 100 or fewer employees. The reviewers certify that our plans meet the requirements for “Qualified Health Plans” with respect to the Affordable Care Act.

Vision services

When seeing your child’s vision service provider for services, or calling VSP® to inquire about his or her benefits, make sure to specify your child’s two-part identification number, which consists of your subscriber ID (located on the front, left-hand side of your ID card) and the member number (located on the front, right-hand side of your ID card.) Please note that your dependents have their own unique member number.

Turn the page to find a comparison of all of our qualified health plans.
## Blue Cross and Blue Shield of Vermont

### 2017 plans and premiums

#### Qualified Health Plans

<table>
<thead>
<tr>
<th>PLAN BENEFITS</th>
<th>Gold</th>
<th>Silver</th>
<th>Gold CDHP (HDHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Rewards Health and Wellness Plans</td>
<td>Health Savings Account (HSA)</td>
<td>[●]</td>
<td>[●]</td>
</tr>
<tr>
<td>Financial accounts</td>
<td>Health Reimbursement Arrangement (HRA)</td>
<td>(available only through an employer)</td>
<td>[●]</td>
</tr>
</tbody>
</table>

#### Medical

| Individual plan deductible | $1,250 aggregate | $2,300 aggregate | $2,500 aggregate |
| Individual plan out-of-pocket maximum | $4,250** | $7,150** | $2,500 |
| Medical cost-sharing | preventive care: visit [www.bcbsvt.com/preventive](http://www.bcbsvt.com/preventive) for the full list of preventive services covered at $0 | $0 | $0 | $0 |
| | primary care provider or mental health visits | deductible, then $30 | deductible, then $50 | deductible, then $0 |
| | specialist visits | deductible, then $250 | deductible, then $400 | deductible, then $0 |
| | emergency visits | deductible, then $500 | deductible, then $1,150 | deductible, then $0 |

#### Pharmacy

| Individual prescription deductible | combined with medical | combined with medical | combined with medical | co |
| Individual prescription out-of-pocket maximum | $1,300 | $1,300 | $1,300 |
| Prescription drugs cost-sharing | deductible, then $5/40%/60% | deductible, then $5/40%/60% | deductible, then $5/40%/60% | $5/40%/60% |
| Monthly premiums | single | $582.30 | $507.01 | $553.14 |
| | two person | $1,929.80 | $1,014.02 | $1,167.28 |
| | adult and child or children | $1,231.29 | $978.53 | $1,027.56 |
| | family | $1,449.43 | $1,242.70 | $1,554.32 |

**Please note that the Blue Rewards Bronze CDHP no longer meets federal requirements to be paired with a Health Savings Account (HSA).**

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### Deductible types

- **Aggregate** deductible: you meet the family deductible before any family member receives post-deductible benefits. With an aggregate deductible, a two-person plan or family must meet the family deductible before any family member receives post-deductible benefits.

- **Stacked** deductible: you meet an aggregate deductible before receiving post-deductible benefits. When the family meets the family deductible, all family members receive post-deductible benefits.

### Standard Plans

<table>
<thead>
<tr>
<th>Plans</th>
<th>PLATINUM</th>
<th>GOLD</th>
<th>SILVER</th>
<th>BRONZE</th>
<th>SILVER CDHP (HDHP)</th>
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<td><strong>BRONZE CDHP</strong></td>
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<td><strong>PLATINUM</strong></td>
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<tr>
<th><strong>Premium</strong></th>
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<th><strong>Annual Out-of-Pocket Max</strong></th>
<th><strong>Out-of-Pocket Max</strong></th>
<th><strong>Annual Out-of-Pocket Max</strong></th>
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**Combined with medical**

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<tr>
<th><strong>Premium</strong></th>
<th><strong>Deductible</strong></th>
<th><strong>Annual Out-of-Pocket Max</strong></th>
<th><strong>Out-of-Pocket Max</strong></th>
<th><strong>Annual Out-of-Pocket Max</strong></th>
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<td>$25/40%/60%</td>
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<td>$15/60%/50%</td>
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</table>

**Combined with medical**

<table>
<thead>
<tr>
<th><strong>Premium</strong></th>
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<th><strong>Annual Out-of-Pocket Max</strong></th>
<th><strong>Out-of-Pocket Max</strong></th>
<th><strong>Annual Out-of-Pocket Max</strong></th>
<th><strong>Out-of-Pocket Max</strong></th>
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<tr>
<td>$438.18</td>
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<tr>
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<td>$1,463.79</td>
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</table>

**Note:** Regardless of all other cost-sharing, if one individual's out-of-pocket costs reach $7,150 in a year, we begin paying 100 percent of the allowed amount for that person's covered services and supplies.
Earn up to $300
with employee health and wellness rewards

As a Blue Cross and Blue Shield of Vermont Blue Rewards ProgramSM member, you are automatically eligible to enroll in the Blue Rewards Health and Wellness Program. You can earn up to $300 for engaging in healthy behaviors during the year.

Earning and using your reward dollars

Once you have registered with the My Blue Health and Wellness CenterSM and completed any of the activities listed in 2 through 5 at right, we will send you a health and wellness rewards debit card containing your first cash reward (Please allow four to six weeks to receive your first reward; subsequent rewards will be added to your card within one week.) You may complete the four activities in any order.

As you complete the activities, we will automatically add rewards dollars to your card, which works like a debit card. You can use your rewards dollars at many health and wellness vendors. You can even use your rewards dollars to help fund your HealthEquity® health savings account (if applicable).

Use your rewards for such expenses as:
- Gyms, spas and health clubs
- Massage therapists and acupuncturists
- Golf courses
- Outdoor activity centers
- Dental and vision providers
- Naturopathic remedies

To view the complete vendor list, log on to My Blue Health and Wellness Center at https://mybluehealth.bcbsvt.com.

Getting started is simple

1. Set up your account at My Blue Health and Wellness CenterSM

My Blue Health is Blue Cross and Blue Shield of Vermont's online health and wellness center. This is where you will keep track of your activities and rewards, complete your health assessment, record completion of your dental/vision exam, and set your personal health goals.

2. Take the online health assessment

The health assessment is a confidential online questionnaire, which provides you with a picture of your overall health. It is an important step to recognize and understand your health risks. Once you complete the health assessment, you automatically earn $50. This will display as 50 points under the 2017 Incentives box in My Blue Health.

3. Set a personal health goal

Setting a goal will help you stay focused and maintain motivation as you work toward a specific outcome. When setting your personal health goal, keep in mind to keep it SMART (SMART is an acronym for Specific, Measurable, Achievable, Realistic and contains a Targeted completion date.) Once you enter your goal and click “Submit”, you will automatically earn $50.

4. Get an annual preventive care check-up with your primary care provider

Age-appropriate exams and screenings can help detect health risks early on. Once your provider bills us for your check-up, we will reward you $100. (If you don’t have a doctor that you see regularly, we can help you find one. Visit www.bcbsvt.com/find-a-doctor or call customer service at (800) 247–2583.)

5. Get a dental check-up or vision exam

Get a dental cleaning and exam or a preventive vision exam to earn another $100 (limit one reward per calendar year). Log on to My Blue Health and record the completion of your exam.

For more information about the Blue Rewards program or for assistance logging onto your account, please call BCBSVT customer service: (800) 247–2583.
## BCBSVT Blue Rewards Gold and Silver Plans (3-6-9 benefits)

### General cost-sharing (applies to most services before we provide benefits)

<table>
<thead>
<tr>
<th>Deductible (aggregate)</th>
<th>Out-of-pocket limit (aggregate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,250 (Gold) or $2,300 (Silver) if you have a single plan</td>
<td>$4,250 (Gold) or $7,150 (Silver) if you have a single plan</td>
</tr>
<tr>
<td>$2,500 (Gold) or $4,600 (Silver) if you have a two-person or family plan</td>
<td>$8,500 (Gold) or $14,300 (Silver) if you have a two-person or family plan</td>
</tr>
</tbody>
</table>

Regardless of all other cost-sharing, if one individual's out-of-pocket costs reach $2,150 in a year, we begin paying 100 percent of the allowed amount for that person's covered services and supplies.

### YOU PAY          PLAN PAYS (NETWORK PROVIDERS ONLY)

#### OUTPATIENT CARE

**preventive care (see pages 20-21)**
Includes well baby, adult preventive, gynecological preventive office visits; includes preventive services such as laboratory, x-ray, screening mammograms, PAP tests and colonoscopies. Excludes diagnostic services.

- **primary care provider office visits**
  - Deductible, then $20 (Gold) or $30 (Silver) co-payment per visit after you meet your deductible.
  - Your deductible does not apply to a certain number of visits each year with a primary care physician or mental health professional:
    - If you have a single plan, you get three visits before your deductible applies.
    - If you have a two-person plan, you get six visits between the two of you before your deductible applies.
    - If you have a family plan, you get nine visits total for the family before your deductible applies.

- **mental health and substance abuse office visits**
  - Required prior approval
  - Deductible, then $30 (Gold) or $50 (Silver) co-payment per visit after you meet your deductible.

- **specialist office visits**
  - May require prior approval
  - Deductible, then $500 (Gold) or $1,500 (Silver) co-payment.

- **maternity office visits**
  - Includes well baby, adult preventive, gynecological preventive office visits; includes preventive services such as laboratory, x-ray, screening mammograms, PAP tests and colonoscopies. Excludes diagnostic services.
  - Deductible, then $30 (Gold) or $50 (Silver) co-payment per visit.
  - For maternity, one co-payment covers all prenatal and postnatal care by one provider.

- **diagnostic services**
  - Includes labs, x-ray, etc.; may require prior approval
  - Deductible, then $250 (Gold) or $400 (Silver) co-payment per visit after you meet your deductible.

- **outpatient physical, occupational and speech therapy**
  - Up to 30 visits combined per calendar year
  - Deductible, then $30 (Gold) or $50 (Silver) co-payment per visit.

- **outpatient surgery**
  - May require prior approval
  - Deductible, then $500 (Gold) or $1,500 (Silver) co-payment per visit.

- **emergency care**
  - Deductible, then $250 (Gold) or $400 (Silver) co-payment per visit after you meet your deductible.

- **urgent care at an urgent care center**
  - Deductible, then $30 (Gold) or $50 (Silver) co-payment.

### INPATIENT CARE

- **inpatient care, general hospital**
  - Includes maternity, newborn care, mental health and substance abuse.
  - Deductible, then $500 (Gold) or $1,500 (Silver) co-payment per admission.

### HOME CARE AND REHABILITATION SERVICES

- **inpatient skilled nursing or rehabilitation**
  - Prior approval required for rehabilitation.
  - Deductible, then $500 (Gold) or $1,500 (Silver) co-payment per admission.

- **home health and hospice care services**
  - Prior approval required for hospice.
  - For home care, deductible, then $30 (Gold) or $50 (Silver) co-payment per visit.
  - For hospice, deductible, then no charge.

### OTHER SERVICES

- **ambulance**
  - Prior approval required for non-emergency transport.
  - Deductible, then $30 (Gold) or $50 (Silver) co-payment.

- **medical equipment and supplies**
  - Prior approval may be required.
  - You pay one co-payment for your vision exam and one for vision materials.

- **pediatric vision exam (up to age 21)**
  - One exam per year, limited materials
  - Deductible, then $0 (class 1), 30% (class 2) or 50% (class 3).

- **pediatric dental (up to age 21)**
  - Please see page 9
  - Deductible, then $0 (class 1), 30% (class 2) or 50% (class 3).

### PRESCRIPTION DRUGS

- **prescription drugs (including home delivery)**
  - Prior approval may be required
  - Deductible, then $5 co-payment for generics, 40% co-insurance for preferred brand-name drugs and 60% co-insurance for non-preferred brand-name drugs. Your costs are limited to $1,300 each year if you have an individual plan or $2,600 each year if you have a two-person or family plan.

These plans employ aggregate deductibles and out-of-pocket limits (including your prescription out-of-pocket limits). If you have a two-person or family plan, your family members’ expenses combined must meet the entire $2,500 (Gold) or $4,600 (Silver) family deductible each year before we begin paying benefits. When your entire family’s expenses combined meet the $8,500 (Gold) or $14,300 (Silver) out-of-pocket limit, we pay 100% of all allowed amount for all covered expenses for the rest of the year. Prescription drugs have lower out-of-pocket limits. See below.
We offer four Consumer-Directed Health Plans (or CDHPs) to employers of 100 and fewer employees, three of which are also High Deductible Health Plans (HDHPs) that can pair with Health Savings Accounts. Our Standard and Blue Rewards CDHP plans appear on pages 16–17.

**Consumer-Directed Health Plans**

Employees can save money tax free for health care costs, and — in some cases — roll over those funds year after year. Rewards come from coupling tax-free earnings with smart purchasing decisions like using lower-cost generic drugs.

Members of CDHPs may maintain tax-favored savings accounts to pay health care cost-sharing expenses. They may draw funds from Health Savings Accounts (HSAs) or an employer-sponsored Health Reimbursement Arrangements (HRAs) to pay out-of-pocket costs for qualified medical expenses — for example, costs they incur while meeting their deductibles.

**Consumers like CDHPs that pair with HRAs and HSAs because they can:**

- Save money through pre-tax contributions for future health care costs (an HSA is like a 401(k) for health care)
- Save money on premiums (CDHPs can be more affordable than standard plans)
- Buy items like eyeglasses or dental treatments that their health plans don’t cover (please see page 15)

**Employers might consider CDHP plans because these accounts:**

- Support smart consumer choices like buying generic drugs and monitoring health costs and medical bills closely
- Engage employees in health improvement
- Cost less than health plans with lower deductibles

**What are Health Reimbursement Arrangements (HRAs)?**

HRAs are accounts set up and funded only by employers from which employees may draw funds to cover qualified medical expenses. When an employee leaves employment, HRA funds stay with the employer. Similarly, if funds are not used in a calendar year, they may remain with the employer if the employer chooses this option.

Employers that offer HRAs must develop plan documents stating for which qualified medical expenses their employees may use HRA funds. A plan document may 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.

Employers may opt to allow funds to carry over from year to year, and 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.

**What are Health Savings Accounts (HSAs)?**

An HSA is also a tax-favored health care spending account. Employees and/or employers may make tax-favored deposits into HSAs. Employees may then draw funds from these accounts 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.

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. 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.

It is important to know the expenses for which you may use your tax-favored HSA. 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. See the next page for details, including a link to IRS information.
HSA considerations

HSAs (and HRAs) are not for everyone. Generally, an HSA might not be right 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.

Qualified medical expenses

The IRS determines for which “qualified expenses” you may use your HSA funds. They include medical, dental (please see page 9), vision and prescription expenses. See IRS publication 502 for a list of specific examples. Examples of qualified medical expenses include:

- Acupuncture
- Amounts not covered under another health plan
- Artificial limbs/teeth
- Body scans
- Post-mastectomy breast reconstruction surgery
- Chiropractor
- Contact lenses
- Crutches
- Dental treatments
- Eye glasses/eye surgery
- Hearing aids
- Long-term care expenses
- Medicines (prescribed)
- Nursing home medical care
- Nursing services
- Optometrist
- Orthodontia
- Oxygen
- Smoking cessation programs
- Surgery, other than unnecessary cosmetic surgery
- Telephone equipment for the hearing-impaired
- Therapy
- Transplants
- Weight-loss programs (prescribed)
- Wheelchairs
- Wigs (prescribed)

Non-qualified medical expenses

The penalty for using HSA funds for non-qualified expenses is 20 percent if you are under age 65, plus the loss of tax-free treatment for the distribution. Keep all itemized receipts and copies of prescriptions for over-the-counter medications in case of an IRS audit. Some non-qualified medical expenses include:

- Concierge services
- Dancing lessons
- Diaper services
- Elective cosmetic surgery
- Electrolysis or hair removal
- Funeral expenses
- Future medical care
- 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)

Over-the-counter medication

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.

Setting up an account

An employer may set up an HRA with any HRA administrator. Employees may select any financial institution for their HSAs. BCBSVT can help, however, with a totally integrated financial solution. We have a relationship with HealthEquitySM, a national expert in HSAs and HRAs. Employers and employees who select HealthEquity for their accounts can count on:

- Claims processing integrated with health savings or reimbursement account reimbursement
- A debit card that will only allow purchases of qualified services or supplies (see the list at left)
- Useful tools that help members manage their accounts, such as a mobile app.
BCBSVT Silver and Bronze Consumer-Directed Health Plans
(Standard CDHP Plans)

General cost-sharing (applies to most services before we provide benefits)

<table>
<thead>
<tr>
<th>Deductible (aggregate)</th>
<th>Out-of-pocket limit (aggregate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,550 (Silver) or $5,050 (Bronze) if you have a single plan</td>
<td>$6,400 (Silver) or $6,550 (Bronze) if you have a single plan</td>
</tr>
<tr>
<td>$3,100 (Silver) or $10,100 (Bronze) if you have a two-person or family plan</td>
<td>$12,800 (Silver) or $13,100 (Bronze) if you have a two-person or family plan</td>
</tr>
</tbody>
</table>

Deductible (aggregate)

- $1,550 (Silver) or $5,050 (Bronze) if you have a single plan
- $3,100 (Silver) or $10,100 (Bronze) if you have a two-person or family plan

Out-of-pocket limit (aggregate)

- $6,400 (Silver) or $6,550 (Bronze) if you have a single plan
- $12,800 (Silver) or $13,100 (Bronze) if you have a two-person or family plan

These plans employ aggregate deductibles and out-of-pocket limits (including your prescription drug out-of-pocket limit). If you have a single plan, your family members’ expenses combined must meet the aggregate deductible each year before we begin paying benefits. When your family members’ expenses combined meet the aggregate out-of-pocket limit, we pay 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. Regardless of all other cost-sharing, if one individual’s out-of-pocket costs reach $7,750 in a year, we begin paying 100% of the allowed amount for that person’s covered services and supplies.

<table>
<thead>
<tr>
<th>OUTPATIENT CARE</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>preventive care (see pages 20-21)</td>
<td>No member cost</td>
<td>100% of the allowed amount</td>
</tr>
<tr>
<td>primary care provider office visits</td>
<td>Deductible, then 10% (Silver) or 50% (Bronze) co-insurance.</td>
<td>90% (Silver) or 50% (Bronze) after deductible</td>
</tr>
<tr>
<td>mental health and substance abuse office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>specialist office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>chiropractic care</td>
<td>prior approval required</td>
<td></td>
</tr>
<tr>
<td>diagnostic services includes labs, X-ray, etc., may require prior approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td>outpatient surgery prior approval required after 12 visits per year</td>
<td>Deductible, then 25% (Silver) or 50% (Bronze) co-insurance.</td>
<td>75% (Silver) or 50% (Bronze) after deductible. After you meet your out-of-pocket limit (above), we pay 100% of our allowed amount for the rest of the year.</td>
</tr>
<tr>
<td>outpatient physical, occupational and speech therapy up to 30 visits combined per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>emergency and urgent care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>maternity office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>maternity prenatal and postnatal care</td>
<td>Deductible, then 10% (Silver) co-insurance.</td>
<td>90% (Silver) after deductible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INPATIENT CARE</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>inpatient care, general hospital</td>
<td>Deductible, then 25% (Silver) or 50% (Bronze) co-insurance.</td>
<td>After you pay your deductible, we pay 75% (Silver) or 50% (Bronze) until you meet your out-of-pocket limit.</td>
</tr>
<tr>
<td>inpatient skilled nursing or rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>home health and hospice care services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>private duty nursing up to 14 hours per member per calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOME CARE AND REHABILITATION SERVICES</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>inpatient skilled nursing or rehabilitation</td>
<td>Deductible, then 25% (Silver) or 50% (Bronze) co-insurance.</td>
<td>After you pay your deductible, we pay 75% (Silver) or 50% (Bronze) until you meet your out-of-pocket limit.</td>
</tr>
<tr>
<td>home health and hospice care services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>private duty nursing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER SERVICES</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ambulance</td>
<td>Deductible, then 25% (Silver) or 50% (Bronze) co-insurance.</td>
<td>After you pay your deductible, we pay 75% (Silver) or 50% (Bronze) until you meet your out-of-pocket limit.</td>
</tr>
<tr>
<td>medical equipment and supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pediatric vision exam (up to age 21) one exam per year, limited materials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pediatric dental (up to age 21) (please see page 9)</td>
<td>Deductible, then 0% (class 1), 30% (class 2). 50% (class 3).</td>
<td>All but your cost-sharing at the left.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUGS</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>prescription drugs (including home delivery)</td>
<td>Deductible, $10 (Silver) or $12 (Bronze) co-payment for generics, $40 (Silver)/$40 (Bronze) co-insurance for preferred brand-name drugs and 50% (Silver)/60% (Bronze) co-insurance for non-preferred brand-name drugs. Your cost are limited to $1,300 each year if you have an individual plan or $2,600 each year if you have a two-person or family plan.</td>
<td>All but your deductible and co-payments at left. We pay 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.</td>
</tr>
<tr>
<td>wellness drugs</td>
<td>visit <a href="http://www.bcbsvt.com/pharmacy/drug-lists/wellness-drug-list">www.bcbsvt.com/pharmacy/drug-lists/wellness-drug-list</a> to find a list.</td>
<td>For certain drugs that prevent or treat a chronic illness, you do not have to pay your deductible. You pay the cost-sharing for the drugs above.</td>
</tr>
</tbody>
</table>
### BCBSVT Blue Rewards Gold and Bronze Consumer-Directed Health Plans

**General cost-sharing (applies to most services before we provide benefits)**

#### Deductible (aggregate)
- $2,500 (Gold) or $7,150 (Bronze) if you have a single plan
- $5,000 (Gold) or $14,300 (Bronze) if you have a two-person or family plan

#### Out-of-pocket limit (aggregate)
- $2,500 (Gold) or $7,150 (Bronze) if you have a single plan
- $5,000 (Gold) if you have a two-person or family plan; or $7,150 individual/$14,300 family aggregate (Bronze)

### YOU PAY

<table>
<thead>
<tr>
<th>Service</th>
<th>Deductible, then 0% co-insurance.</th>
<th>100% after deductible.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTPATIENT CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>preventive care (see pages 20-21)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>primary care provider office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mental health and substance abuse office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>specialist office visits</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>maternity office visits</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>chiropractic care prior approval required after 12 visits per year</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>diagnostic services includes laboratory and x-ray</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>outpatient surgery prior approved may be required</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>outpatient physical, occupational and speech therapy up to 30 visits combined per calendar year</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>emergency or urgent care</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td><strong>INPATIENT CARE</strong></td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>inpatient care, general hospital</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>includes maternity, newborn care, mental health and substance abuse.</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td><strong>HOME CARE AND REHABILITATION SERVICES</strong></td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>inpatient skilled nursing or rehabilitation</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>Prior approval required for rehabilitation</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>home health and hospice care services</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>prior approval required</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>private duty nursing</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>Prior approval required. Up to 14 hours per member per calendar year.</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td><strong>OTHER SERVICES</strong></td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>ambulance prior approval required for non-emergency transport</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>medical equipment and supplies prior approval may be required</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>pediatric vision exam (up to age 21) one exam per year, limited materials</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
<tr>
<td>pediatric dental (up to age 21) (please see page 9)</td>
<td>Dudley, then 0% co-insurance.</td>
<td>100% after deductible.</td>
</tr>
</tbody>
</table>

### PRESCRIPTION DRUGS

- prescription drugs (including home delivery) prior approval may be required
  - Deductible, then $0 co-insurance. Your costs are limited to $1,300 each year if you have an individual plan or $2,600 each year if you have a two-person or family plan.
  - All but your deductible. We pay 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.

- wellness drugs
  - For certain drugs that prevent or treat a chronic illness, you do not have to pay your deductible. Instead, you pay a $5 (Gold) or $25 (Bronze) co-payment for generics, 40% co-insurance for preferred brand-name drugs and 60% co-insurance for non-preferred brand-name drugs.
  - All but the cost-sharing at the left.

This plan employs **aggregate deductibles and out-of-pocket limits (including your prescription out-of-pocket limits)**. If you have a two-person or family plan, your family members’ expenses combined must meet the entire $5,000 (Gold) or $14,300 (Bronze) family deductible each year before we begin paying benefits. When your entire family’s expenses combined meet the $5,000 (Gold) or $14,300 (Bronze) out-of-pocket limit, we pay 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.
### BCBSVT Platinum, Gold and Silver Plans (Non-CDHP Standard Plans)

#### General cost-sharing (applies to most services before we provide benefits)

<table>
<thead>
<tr>
<th>Deductible (stacked)</th>
<th>Out-of-pocket limit (stacked)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual: $250 (Platinum), $850 (Gold) or $2,150 (Silver)</td>
<td>Individual: $1,300 (Platinum), $4,500 (Gold) or $6,000 (Silver) if you have a single plan</td>
</tr>
<tr>
<td>Two-person or family: $500 (Platinum), $1,700 (Gold) or $4,300 (Silver)</td>
<td>Two-person or family: $2,600 (Platinum), $9,000 (Gold) or $12,000 (Silver)</td>
</tr>
</tbody>
</table>

These plans employ **stacked deductibles and out-of-pocket limits**. Each individual in your family need only meet the individual deductible each year before we begin 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, we pay 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, we pay 100% for all covered expenses for the rest of the year.

#### OUTPATIENT CARE

<table>
<thead>
<tr>
<th>Service</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care (see page 16)</td>
<td>No member cost.</td>
<td>100% of the allowed amount.</td>
</tr>
<tr>
<td>Includes well baby, adult preventive,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>gynecological preventive office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>includes preventive services such as</td>
<td></td>
<td></td>
</tr>
<tr>
<td>laboratory, screening mammograms, PAP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>tests and colonoscopies. Excludes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diagnostic services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care provider office visits</td>
<td>$10 (Platinum), $15 (Gold) or $25 (Silver) co-payment per visit.</td>
<td>All but your co-payments.</td>
</tr>
<tr>
<td>Mental health and substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>office visits</td>
<td>$30 (Platinum), $30 (Gold) or $65 (Silver) co-payment per visit.</td>
<td>All but your co-payments.</td>
</tr>
<tr>
<td>Specialist office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May require prior approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity office visits</td>
<td></td>
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</tr>
<tr>
<td>Prior approval required after 12 visits per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic care prior approval</td>
<td>Deductible, then 10% (Platinum), 20% (Gold) or 40% (Silver) co-insurance.</td>
<td>After you pay your deductible, we pay 90% (Platinum), 80% (Gold) or 60% (Silver).</td>
</tr>
<tr>
<td>Diagnostics includes labs, X-ray, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May require prior approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery prior approved may be required</td>
<td>Co-payment for ER facility charge: $100 (Platinum), $150 (Gold). Deductible, then $250 (Silver).</td>
<td>All but your co-payments.</td>
</tr>
<tr>
<td>Outpatient physical, occupational and speech therapy</td>
<td>$30 (Platinum), $30 (Gold) or $65 (Silver) co-payment per visit.</td>
<td>All but your co-payments.</td>
</tr>
<tr>
<td>To up 30 outpatient rehabilitation visits per plan year and up to 30 visits for habilitation services per plan year</td>
<td>$30 (Platinum), $30 (Gold) or $65 (Silver) co-payment per visit.</td>
<td>All but your co-payments.</td>
</tr>
<tr>
<td>Emergency care</td>
<td>Co-payment for ER facility charge: $100 (Platinum), $150 (Gold). Deductible, then $250 (Silver).</td>
<td>All but your co-payments.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$40 (Platinum) $45 (Gold) or $60 (Silver) co-payment.</td>
<td>All but your co-payments.</td>
</tr>
</tbody>
</table>

#### INPATIENT CARE

<table>
<thead>
<tr>
<th>Service</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient care, general hospital</td>
<td>Deductible, then 10% (Platinum), 20% (Gold) or 40% (Silver) co-insurance.</td>
<td>After you pay your deductible, we pay 90% (Platinum), 80% (Gold) or 60% (Silver).</td>
</tr>
<tr>
<td>Includes maternity, newborn care,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mental health and substance abuse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home care and rehabilitation services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior approval required for rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health and hospice care services</td>
<td>Deductible, then 10% (Platinum), 20% (Gold) or 40% (Silver) co-insurance.</td>
<td>After you pay your deductible, we pay 90% (Platinum), 80% (Gold) or 60% (Silver).</td>
</tr>
<tr>
<td>Private duty nursing</td>
<td>Deductible, then 10% (Platinum), 20% (Gold) or 40% (Silver) co-insurance.</td>
<td>After you pay your deductible, we pay 90% (Platinum), 80% (Gold) or 60% (Silver).</td>
</tr>
<tr>
<td>Up to 14 hours per member per calendar year</td>
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</tbody>
</table>

#### OTHER SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>$50 (Platinum and Gold) or $100 (Silver) co-payment per member per day.</td>
<td>All but your $50 or $100 co-payment.</td>
</tr>
<tr>
<td>Medical equipment and supplies</td>
<td>Deductible, then 10% (Platinum), 20% (Gold) or 40% (Silver) co-insurance.</td>
<td>After you pay your deductible, we pay 90% (Platinum), 80% (Gold) or 60% (Silver).</td>
</tr>
<tr>
<td>Prior approval may be required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric vision exam (up to age 21)</td>
<td>$30 (Platinum), $30 (Gold) or $65 (Silver) co-payment. You pay one co-payment for your exam and one for materials.</td>
<td>All but your co-payments.</td>
</tr>
<tr>
<td>One exam per year, limited materials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior approval may be required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric dental (up to age 21)</td>
<td>0% (class 1). Deductible, then 30% (class 2) or 50% (class 3).</td>
<td>50-100% of our allowed amount depending on service.</td>
</tr>
<tr>
<td>(please see page 5)</td>
<td></td>
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</tr>
</tbody>
</table>

#### PRESCRIPTION DRUGS

<table>
<thead>
<tr>
<th>Service</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription drugs (including home delivery)</td>
<td>You pay $0 (Platinum) $100 (Gold) or $150 (Silver) drug deductible for brand-name drugs, then:</td>
<td>All but your deductibles for brand-name drugs only and only on Gold and Silver plans and the co-payments at left. We pay 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.</td>
</tr>
<tr>
<td></td>
<td>• Platinum and Gold: $5 co-payment for generics, $50 co-payment for preferred brand-name drugs and 50% co-insurance for non-preferred brand-name drugs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Silver: $15 for generics, $60 for preferred brand-name drugs and 50% co-insurance for non-preferred brand-name drugs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Your costs are limited to $1,300 each year if you have an individual plan or $2,600 each year if you have a two-person or family plan.</td>
<td></td>
</tr>
</tbody>
</table>
### General cost-sharing (applies to most services before we provide benefits)

**Deductible (aggregate)**
- $4,600 if you have a single plan
- $9,200 if you have a two-person or family plan

**Out-of-pocket limit (aggregate)**
- $7,150 if you have a single plan
- $14,300 if you have a two-person or family plan

### OUTPATIENT CARE

<table>
<thead>
<tr>
<th>Service</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care (see pages 20-21)</td>
<td>No member cost</td>
<td>100% of the allowed amount</td>
</tr>
<tr>
<td>Includes well baby, adult, preventive, gynecological preventive office visits; includes preventive services such as laboratory, screening mammograms, PAP tests and colonoscopies. Excludes diagnostic services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care provider office visits</td>
<td>Deductible, then $35 per visit.</td>
<td>All but your co-payments.</td>
</tr>
<tr>
<td>Mental health and substance abuse office visits</td>
<td>Deductible, then $90 co-payment per visit.</td>
<td>All but your co-payments.</td>
</tr>
<tr>
<td>Maternity office visits may require prior approval</td>
<td>Deductible, then 50% co-insurance.</td>
<td>50% after you meet your deductible.</td>
</tr>
<tr>
<td>Chiropractic care prior approval required after 12 visits per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic services includes laboratory and X-ray</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient physical, occupational and speech therapy up to 30 visits combined per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency care</td>
<td>Deductible, then $100 per visit.</td>
<td>All but your co-payments.</td>
</tr>
<tr>
<td>Urgent care: care at an urgent care center</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INPATIENT CARE

<table>
<thead>
<tr>
<th>Service</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient care, general hospital</td>
<td>Deductible, then 50% co-insurance.</td>
<td>After you pay your deductible, we pay 50% until you meet your out-of-pocket limit. Then we pay 100% of our allowed amount.</td>
</tr>
<tr>
<td>Includes maternity, newborn care, mental health and substance abuse.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HOME CARE AND REHABILITATION SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient skilled nursing or rehabilitation prior approval required for rehabilitation</td>
<td>Deductible, then 50% co-insurance.</td>
<td>After you pay your deductible, we pay 50% until you meet your out-of-pocket limit. Then we pay 100% of our allowed amount.</td>
</tr>
<tr>
<td>Home health and hospice care services prior approval required</td>
<td>Deductible, then 50% co-insurance.</td>
<td>After you pay your deductible, we pay 50% until you meet your out-of-pocket limit. Then we pay 100% of our allowed amount.</td>
</tr>
<tr>
<td>Private duty nursing up to 14 hours per member per calendar year.</td>
<td>Deductible, then 50% co-insurance.</td>
<td>After you pay your deductible, we pay 50% until you meet your out-of-pocket limit. Then we pay 100% of our allowed amount.</td>
</tr>
</tbody>
</table>

### OTHER SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance: prior approval required for non-emergency transport</td>
<td>Deductible, then $100 co-payment per member per day.</td>
<td>All but your deductible and co-payment.</td>
</tr>
<tr>
<td>Medical equipment and supplies prior approval may be required</td>
<td>Deductible, then 50% co-insurance.</td>
<td>After you pay your deductible, we pay 50% until you meet your out-of-pocket limit. Then we pay 100% of our allowed amount.</td>
</tr>
<tr>
<td>Pediatric vision exam (up to age 21) one exam per year, limited materials</td>
<td>Deductible, then $90 co-payment for exam and $90 co-payment for materials.</td>
<td>All but your co-payments.</td>
</tr>
<tr>
<td>Pediatric dental (up to age 21) (please see page 9)</td>
<td>No deductible, then 0% (class 1). Deductible, then 30% (class 2). Deductible, then 50% (class 3).</td>
<td>After deductible (on classes 2 and 3)</td>
</tr>
</tbody>
</table>

### PRESCRIPTION DRUGS

<table>
<thead>
<tr>
<th>Service</th>
<th>YOU PAY</th>
<th>PLAN PAYS (NETWORK PROVIDERS ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription drugs (including home delivery) prior approval may be required</td>
<td>Your prescription drug deductible ($700), then $20 co-payment for generics, $85 co-payment for preferred brand-name drugs and 60% co-insurance for non-preferred brand-name drugs. Your costs are limited to $1,300 each year if you have an individual plan or $2,600 each year if you have a two-person or family plan.</td>
<td>All but your deductible and the co-payments at left. We pay 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.</td>
</tr>
</tbody>
</table>
Understanding preventive care

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?
BCBSVT 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. You do not have to pay cost-sharing for these services. You do have to pay cost-sharing for preventive services not on this list.

At Blue Cross and Blue Shield of Vermont (BCBSVT), we 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 guide explains which preventive care is right for you and how we cover various services.
Blue Rewards
3–6–9 benefits for your unique needs

Everyone has unique needs when it comes to their health care benefits. We created our Blue Rewards plans with your individual health and wellness needs in mind to make sure you receive the care you need when you need it.

Through our Blue Rewards Gold or Silver plans, you will receive three, six or nine primary care or mental health visits per calendar year at no cost. The total visits you will receive depends on your membership type.

- Single—three visits
- Couple or parent and child—six visits*
- Family—nine visits*

*You can use visits in any combination across family members.

You will also receive certain lab services performed during these visits at no cost to ensure you’re getting the care you need.
Our pharmacy programs

How our pharmacy benefits work

Some plans have prescription drug deductibles, which may be separate from any other medical deductibles they may have. Some plans have combined overall deductibles. After members meet any applicable deductible, they may pay co-insurance (a percentage of the cost of the drug) or they may pay co-payments each time they purchase prescriptions. Some plans include a combination of co-payments and co-insurance. All plans include an out-of-pocket limit for prescription drugs, which is $1,300 for self-only plans and $2,600 for two-person and family plans. After members have paid this amount, which may include deductibles, co-insurance and/or co-payments, we will begin to cover prescription drugs at 100 percent of our allowed amount.

Keeping costs down

With our three-tier benefit, you pay:
- The lowest payment for generic drugs,
- A higher payment for brand-name drugs that are on BCBSVT’s Preferred Brand-name Drug List, or
- The highest payment for brand-name drugs that are not on BCBSVT’s Preferred Brand-name Drug List (non-preferred drugs).

Convenient refills and savings with our home delivery program

If you use prescription drugs on an ongoing basis, our home delivery program may be a more convenient way for you to buy prescriptions. To begin using our home delivery service for your maintenance drug, visit www.bcbsvt.com/RxCenter for all the details.

Over-the-counter drugs

We cover certain over-the-counter drugs, requiring only a generic-level co-payment from you. For example, if you take Claritin® for allergies or Prilosec OTC® for stomach acid reflux, you may ask for a prescription from your doctor.

With that prescription, your pharmacist can dispense up to a 30-day supply of the medication and charge you just the co-payment you normally pay for generic drugs. Check the Rx Center on our website for a list of covered over-the-counter drugs.
Review

We do reviews of certain prescriptions to be sure that our members receive the most cost-effective drugs. You can find the most current list for each type of review at the Rx Center on our website or by calling our customer service department at the number listed on the back of your ID card.

Prior approval

Our prior approval list changes periodically. We require prior approval for drugs that have been on the market less than 12 months, medications without National Drug Code numbers and drugs in certain other categories, for example:

- Angiotensin receptor blockers for hypertension (like Cozaar® or Diovan®)
- Non-sedating antihistamines (like Clarinex® or Xyzal®)
- Anti-migraine agents
- Anti-virals (like Valtrex® or Famcyclovir®)
- Asthma control medications (like Symbicort® and Advair®)
- Beta Blocker Medications
- Bisphosphonates (like Boniva® or Actonel®)
- COX-2 inhibitors (like Celebrex®)
- Certain medications for depression (like Lexapro® or Cymbalta®)
- Diabetes management and treatment drugs (like blood glucose supplies, DPP IV and TZDs)
- Hypertension drugs for treating high blood pressure and other heart diseases (like Bystolic® and Coreg®)
- Hypnotics (sleeping pills like Lunesta® or Rozerem®)
- Lyrica® (for treating several conditions associated with the nervous system, including neuropathy)
- Nasal steroids (Like Rhinocort AQ® or Nasacort AQ®)
- Neuropathic pain medications
- Osteoporosis agents
- Selective serotonin reuptake inhibitors
- Statins (cholesterol-lowering drugs like Lipitor® 10 and 20 mg)
- Stomach acid medications (like Nexium® or Prevacid®)
- Triptans for the treatment of migraine headaches

Quantity limits

If your doctor prescribes a drug in an amount that exceeds certain criteria, such as the manufacturer’s recommendations, we may ask for documentation about why you need more of the drug. Here are examples of types of drugs on which we place quantity limits:

- Biologics and other such medications
- Chemotherapeutics
- Growth hormone replacement therapy
- Hepatitis C medications
- Certain pain medications, such as opiates
- Primary pulmonary hypertension therapy

Step therapy

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

- Anti-emetics
- Anti-fungals
- Anti-histamines
- Anti-hypertensives
- Anti-inflammatory agents
- Biologics
- Glucose test strips
- Inhalers (like Advair®)
- Oncology agents
- Pain medications (like OxyContin®)
- Proton pump inhibitors
- Anti-migraine medications (like Maxalt® or Zomig®)
- Selective serotonin reuptake inhibitors
- Sleeping agents (such as Ambien CR® or Lunesta®)

Visit our website at www.bcbsvt.com/RxCenter or call our customer service team at the number listed on the back of your ID card.

Did you know?

All of our plans now cover generic prescription birth control for up to 12 months at a time at no cost to you.
Blue Health Solutions is our suite of customized health and wellness programs and solutions designed to help employees achieve and maintain optimal health at every stage of life. This program supports members in getting the right care and screenings and helps them be successful with their doctors’ treatment plans. Blue Health Solutions integrates several approaches to helping our members maintain healthy lifestyles. We also provide a local touch when it comes to providing case management and health support for prevalent and rare chronic conditions.

Staying healthy

Above all else, we want our members to stay healthy. That’s why we offer many different ways to engage members in maintaining healthy lifestyles. These include:

**Fitness and health events**

Blue Cross and Blue Shield of Vermont holds many signature events each year that help Vermonters get out and get active. They range from walking challenges at Vermont worksites to “Hike, Bike & Paddle” events at Vermont lakes and ponds to “Apple Days” and “Snow Days” at some of our state’s most beautiful venues. See the updated calendar at [www.bcbsvt.com/calendar](http://www.bcbsvt.com/calendar).

**Blue Extras Health and Wellness Program**

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

**My Blue Health and Wellness Center**

By using the tools on the My Blue Health and Wellness Center ([mybluehealth.bcbsvt.com](http://mybluehealth.bcbsvt.com)) link from our site, members can create and manage health improvement programs designed especially for their specific needs—tracking their diet, exercise and overall health. My Blue Health and Wellness Center features a number of exercise tools that allow members to track their physical activity, as well as gain access to fitness plans and exercise demos. They can use My Blue Health on their mobile devices, making it easy to track while they’re on the go.

**Consumer support tools**

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

**Better Beginnings®**

Our popular Better Beginnings program helps our members provide the healthiest, happiest start for their babies. Better Beginnings offers our members pregnancy and postnatal support.

When an employee enrolls in the program, one of our Better Beginnings nurses will work with her health care provider to promote healthy outcomes. The Better Beginnings program has played an important role in lowering our state’s premature birth rate. A premature birth is not only dangerous for a baby, but also for a mother. Our Better Beginnings nurse will work directly with a mom-to-be to identify any risks that could lead to complications with her pregnancy and help to reduce those risks. The program offers a choice of several different benefit options. We will offer an enhanced benefit for members participating before the 34th week of pregnancy.

**A sample of benefits includes:**

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

Our Better Beginnings nurse will review the program benefits with each participant. Because every pregnancy is different, we tailor the program to meet each member’s individual needs.
Getting better

Utilization management

We do not require your participation in prior approval, preadmission review, admission review or concurrent review. Network providers take care of this for you. Please see page 23 for information on reviews required for prescriptions.

Case management

If you suffer a catastrophic health event or have a complex condition, Blue Cross and Blue Shield of Vermont has a case management program to help. While your PCP is the primary resource for medical questions and concerns, a case manager serves as your dedicated advocate at BCBSVT. The case manager will coordinate benefits and find programs, services and support systems that can help support you and your family.

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

Our case managers may provide educational materials about your conditions and treatment plans and coordinate resources so that you get timely and affordable care and use your benefits in the best way.

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

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

Living with illness

Chronic condition management

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

We offer help for a variety of prevalent conditions including:

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

A nurse may reach out to you and touch base about your condition. We want to be sure that you are getting the best care and screening available and help you stay on track with your treatment plan. Conversations with disease management participants are strictly confidential and participation in the program is always voluntary.

Rare condition management

Some conditions are less prevalent, making them potentially more costly and hard to manage, but we can offer specialized help when local support may be hard to find. We can connect you to nurses who have expert knowledge of rare conditions. This one-on-one help is designed to help improve your total health and manage your multiple and complex conditions. Support could include symptom management, self-care support, medication optimization and care optimization.

Rare conditions addressed through our program include:

- 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

We’ll see you through

The health and wellness of our members is most important to us at Blue Cross and Blue Shield of Vermont. Whether it’s helping members stay healthy, get better, or live with a chronic illness, we make good on our promise to support them every step of the way. The health care coverage provided by our independent, Vermont-based company has brought security and stability to Vermont families for nearly 70 years, and we are committed to doing so for many years to come. We’ll see you through.
General exclusions

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

- Services that are investigational, experimental, cosmetic or not medically necessary as defined in your certificate of coverage.
- Non-medical charges like fees for completion of a claim form, personal service items or home modifications.
- Providers who are not approved to provide a particular service or who don’t meet the definition of “provider” in your certificate.

If you would like to review our complete list of general exclusions before enrolling, go to www.bcbsvt.com/contracts. Click on the plan in which you are enrolling and read the chapter entitled “Exclusions.” Once enrolled, you will receive your Certificate of Coverage which details all general exclusions. Please read your certificate carefully; it is a part of your contract which governs your benefits.

How we protect your privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You have the right to gain access to your health information and to information about our privacy practices. Our Notice of Privacy Practices is available on our website, www.bcbsvt.com/privacypolicies, which includes information on:

- Our routine use and disclosure of personal health information (PHI). The protection of information disclosed to Plan sponsors or to employers.
- The protection of oral, written and electronic information across the organization.

Special enrollment

You may add dependents for any reason during the open enrollment period for Qualified Health Plans each year.

You may add a dependent or change your coverage during a special enrollment period. Generally, you have 60 days from the date of the qualifying event to change your coverage. If you don’t add or change your coverage within 60 days, you will have to wait until open enrollment to change your coverage. You are entitled to a special enrollment period when one of the following occurs:

- marriage;
- pregnancy¹;
- birth or adoption;
- loss of coverage (other than for failure to pay);
- newly qualifying for coverage;
- eligibility based on permanent move;
- addition of court-ordered dependents; or
- losing coverage due to domestic violence.

¹ New enrollees and adds only (no plan changes allowed). Pregnant person must enroll in coverage, or qualifying household members may also enroll any time during pregnancy up to date of birth.
Marriage

When you marry, you may add your spouse and his or her dependents to your membership. Your new dependent or dependents may enroll on your current plan, or you and your dependent(s) may change to any other plan your employer offers. We must receive your request within 60 days after the date of your marriage. Generally, your new membership becomes effective the first day of the month after the marriage. If you fail to add your new dependent within 60 days of your marriage or civil union, you must wait until an open enrollment period to do so.

Birth or adoption

If you already have a family membership, we cover your new child from the date of birth, legal placement for adoption or legal adoption. You must, however, notify us in writing of your family addition within 60 days. If you need to upgrade your membership (to a parent/child or family membership) to include the child, we must receive your application for a membership change in order to continue benefits for the child past 60 days. You may enroll your new dependent or dependents on your current plan, or you and your dependent(s) may change to any other plan your employer offers. The new type of membership becomes effective the 61st day after birth, placement for adoption or adoption.

If you fail to add your new dependents within 60 days, you must wait until an open enrollment period to do so.

Court-ordered dependents

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

Special enrollment rights under “CHIP”

The “Children’s Health Insurance Program Reauthorization Act of 2009” (“CHIP”) requires group health plans to offer special 60-day enrollment periods to employees and their dependents who are not covered by the group plan in two situations:

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

You must request coverage no later than 60 days after losing coverage from Medicaid or Dr. Dynasaur or when the state determines you are eligible for premium assistance. You may choose either the date coverage ends or the first of the month following receipt of a valid enrollment request as the effective date for coverage under your group health plan.

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

For more details on special enrollments, please consult a BCBSVT Certificate of Coverage (at www.bcbsvt.com/contracts) or contact your group benefits manager.

Did you know?

If you are an employee and you doubt your ability to afford the health plan your employer offers you because your contribution or your cost-sharing is too high, Vermont Health Connect can help. Visit http://info.healthconnect.vermont.gov/ESICalculator to see if you qualify for help in paying for your coverage.
NOTICE: Discrimination is against the law

Blue Cross and Blue Shield of Vermont (BCBSVT) complies with applicable federal and state civil rights laws and does 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).

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
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 868-1019
(800) 537-7697 (TDD)
civilrightscoordinator@bcbsvt.com

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

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

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

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

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

FRANCÉS
Pour obtenir des services d’assistance linguistique gratuits, appelez le (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
नि:शुल्क 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.

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

VIETNAMESE
Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (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.