BlueCross BlueShield of Vermont

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

2025 QUALIFIED HEALTH PLANS (QHP) ENROLLMENT GUIDE FOR EMPLOYEES OF SMALL GROUPS

Our plans offer access to the largest network of doctors and hospitals in Vermont. Members can also access providers around the U.S. and globally.

INSIDE:

@bluecrossvt

bluecrossvt.org

ESSENTIAL HEALTH BENEFITS

Our health plans provide the care you want and the customer service experience you deserve. At Blue Cross® and Blue Shield® of Vermont, the difference is in our health plans, our network, and our personalized service. The essential health benefits of our Qualified Health Plans (QHP) include visits to providers' offices, preventive care, prescription drugs, laboratory tests, mental health and substance use disorder treatment services, hospital stays, emergency care, prenatal and postnatal maternity care, and vision and dental care for children.

OFFICE SERVICES

PRIMARY CARE

A primary care provider (PCP) coordinates care for our members and refers patients to specialty providers as needed. We encourage our members to develop a relationship with a provider who listens to their opinions and understands their health concerns. To help members find a primary care provider that meets their needs, please visit **bluecrossvt.org/find-doctor**.

PREVENTIVE HEALTH SERVICES

Each of our plans cover in-network preventive health services*, at no cost to members. Examples of preventive services include:

- **Check-ups** – annual wellness visits
- **Screenings** – blood pressure, cholesterol, diabetes, mammograms, colonoscopies, and more
- **Standard immunizations** – flu, tetanus, MMR, etc.

Read more about preventive care at **bluecrossvt.org/preventive**.

**As defined by state and federal law.*

OFFICE VISITS

Our health plans cover services in an office setting with a primary care provider or a specialty provder.*

This means you are covered when you need:

- An examination, diagnosis, and treatment for an injury or illness
- Injections
- Diagnostic services, such as X-rays, and laboratory tests
- Nutritional counseling
- Surgery
- Therapy services

**Services may be subject to cost-share.*

HOSPITAL SERVICES

HOSPITAL CARE

Our health plans provide hospital coverage for inpatient and outpatient services.* Outpatient services may be provided in a hospital or ambulatory surgical center. These services can include surgery, diagnostic services, advanced imaging (MRI, CT, or PET scan), infusion therapy, and chemotherapy. If a member is admitted into the hospital or another type of inpatient facility, and spends one night, the stay is eligible for coverage. Some services may require prior approval.

**Services are subject to cost-share.*

URGENT CARE

When a member has a condition that is not life threatening, but needs immediate attention, an urgent care facility may be the most appropriate option. Urgent care facilities are located throughout Vermont and offer many of the same services as a PCP. Most urgent care facilities have extended hours, including weekends. Our health plans cover* treatments at urgent care facilities.

**Services are subject to cost-share.*

EMERGENCY CARE

Emergency services are covered* regardless of where a member is located when an emergency occurs.

Our health plans do not require prior approval for emergency medical services, regardless of where a member seeks care.

**Services are subject to cost-share.*

Members will have access to two benefit documents:

- The Outline of Coverage which explains their benefits and corresponding costs.
- The Certificate of Coverage which details all covered benefits, limitations, and general exclusions.

ANCILLARY SERVICES

PRESCRIPTION DRUG COVERAGE

Prescription drug coverage is through Vermont Blue Rx℠. Our network of pharmacies can be found throughout Vermont and nationwide. Medications are also available through home delivery. To determine if your medication is covered by Vermont Blue Rx, refer to the National Performance Formulary (NPF) via the link provided below. We also offer our members free medication guidance services with one of our on-staff pharmacists.

For more information about our prescription drug coverage, we have provided these helpful links:

- **National Performance Formulary (NPF)** – Our drug lists include medications that are the most appropriate and cost-effective for treatment. Drug lists can change from time to time, but they outline the prescription and specialty medications covered by our QHP plans. For complete NPF drug lists, visit **bluecrossvt.org/formulary-lists** and choose NPF list.
- **Wellness Drug Benefit -** Some health plans include wellness drug benefits for certain medication types to treat common conditions including (but not limited to): diabetes, asthma, cholesterol, high blood pressure, SSRI/mood, and substance use treatment. Our Vermont Preferred and all Consumer-Directed Health Plans (CDHP) waive the deductible for these medications, but cost-share may still apply based on the drug tier (generic, preferred, and non-preferred brand). For the complete NPF list of our wellness drugs, visit **bluecrossvt.org/formulary-lists**.
- **Home Delivery** – Members can take advantage of our home delivery pharmacy option as a convenient way to buy their prescription drugs. Learn more at **bluecrossvt.org/vtbluerx**.
- **Medication Guidance Program** – These free one-on-one consultations are conducted by our on-staff pharmacists. Members receive a complete prescription medication review, discussing dosages, any side effects and more. To learn more about the program, visit **bluecrossvt.org/medmanage**.

VIRTUAL CARE

24/7 Telemedicine from Amwell®

Members can easily connect with a licensed, board certified doctor via live video on a computer, tablet, or smart phone.* It's a convenient option for common, non-emergency health concerns. Members can sign up or access an account at **bluecrossvt.org.amwell.com**. Virtual mental health is also available from Valera Health® and SonderMind®. To learn more, visit **bluecrossvt.org/telemedicine**.

**Services are subject to cost-share.*

HEALTH AND WELLNESS RESOURCES

If age 21 and older, you can use our free wellness portal, Be Well Vermont℠, powered by Personify Health. Explore health tips and articles, wellness challenges, and more. Members can connect fitness devices and apps, such as Fitbit, to monitor daily activity within the portal. Sign up at **bluecrossvt.org/bewellvt**.

INTEGRATED HEALTH - CASE MANAGEMENT

Our registered nurses, licensed social workers, and behavioral health counselors offer our members free case management resources. We create a personalized plan for improving health and well-being, connecting you to important resources so you can get the support you need.

Members may access our case management team to address a wide range of health needs, including substance use disorder treatment, cancer, chronic conditions, end of life, maternity, and transgender support. To learn more visit **bluecrossvt.org/casemanagement**.

BETTER BEGINNINGS® MATERNAL HEALTH PROGRAM

When expecting mothers enroll in our maternal health program, they partner with one of our experienced Better Beginnings nurses, who coordinates care and provides guidance — both during pregnancy and after their baby is born. Our Better Beginnings nurses connect mothers to home health nurses, lactation consultants, or other resources to help ensure moms can achieve their health, wellness, and parenting goals.

Members should sign up before they are 34 weeks pregnant to take advantage of all the Better Beginnings benefits! To learn more about this program, visit **bluecrossvt.org/betterbeginnings**.

PRIOR APPROVAL

There are times when our health plans may require prior approval for certain services and drugs, even when you use network providers. Network providers will be responsible to submit requests for prior approval on behalf of our members. If you see an out-of-network provider, you must get prior approval before seeking care, except in an emergency. For out-of-state inpatient services with a network provider (BlueCard®), providers are responsible for securing prior authorization. For all other out-of-state services with a network provider (BlueCard®), members are financially liable for no authorization/prior approval denials, regardless of provider network status. You or your provider may fill out the prior authorization form and provide the necessary information to submit the request. For the most recent prior approval list, visit **bluecrossvt.org/priorapproval**.

SERVICES OUR PLANS MAY NOT COVER

Members can be confident that our health plans cover a broad array of necessary services and supplies. Here are some of the services that our health plans generally do not cover:

- Services that are investigational, experimental, cosmetic, or not medically necessary as defined in your Certificate of Coverage or Outline of Coverage, and Summary of Benefits and Coverage.
- Services that should be covered by another source, such as another type of insurance or an employer.
- Providers who are not approved to provide a particular service or don't meet the definition of "provider" in the plan's Certificate of Coverage.

ENROLLMENT RESOURCES

It's important to review the options available through your employer. In most cases, your employer will notify you on the plan option(s) available. The steps below will help you choose a new plan or make changes.

KEEPING YOUR CURRENT COVERAGE

Contact your group benefits administrator to understand your employer's renewal process and learn if you need to take any steps to continue your coverage.

CHOOSING A NEW PLAN

Your group benefits administrator will let you know your options for health plan coverage. To understand what each plan will cover, and your responsibility, review our plan comparison chart. You can also review the Summary of Benefits and Coverage (SBC) for any of the plans your employer offers at **bluecrossvt.org/smallbusiness**.

If you need help with plan options, please contact your group benefits administrator, your employer's broker, or contact us at (800) 255-4550 (TTY/TDD: 711) or email **consumersupport@bcbsvt.com**.

MAKING CHANGES TO YOUR CURRENT COVERAGE

- Please review your available options with your employer for your upcoming Open Enrollment.
- If your employer offers you multiple plans, follow these next steps to make sure you're enrolled in the right health plan for you and your family's needs:
- Review costs through your employer (for example, premium contribution through your paycheck)
- Determine your budget
- Review plan information (i.e. benefits, costs)
- Choose the plan that best meets your needs.
- If you need to make any changes to your enrollment (such as adding/removing your covered family members or choosing a new plan), please notify your group benefits administrator and they will notify us.

HOW TO CHOOSE THE BEST PLAN FOR YOU

1. Determine your budget by considering your:
   - Monthly premiums
   - Benefits and cost share for each plan such as deductible, out-of-pocket limits, copayments, and coinsurance.
   - Prescription drug costs
   - Other costs related to non-recurring medical needs
2. Once you have an idea of what your expenses and budget are, review your health plan options.
3. Enroll in the plan that meets both your health care needs and budget.

WHAT TO CONSIDER

- **Cost** – including premiums, deductibles, out-of-pocket limits, medical and pharmacy benefits.
- **Plan affordability** – if you are unsure you can afford the health plan(s) your employer offers because your contribution responsibility is too high, Vermont Health Connect (VHC) may be able to provide financial help. VHC can assist to determine if your job-based health plan is considered adequate or affordable coverage. If your job-based health plan is considered affordable, you won't qualify for financial help through Vermont Health Connect.

To learn more about your available options, visit **VermontHealthConnect.gov** or call Vermont Health Connect at (855) 899-9600.

ENROLL IN A PLAN

Once you have reviewed available plan options and evaluated your needs, see your benefits administrator to enroll. They will have the necessary forms to complete and they will submit them to Blue Cross VT for you.

OPEN ENROLLMENT IMPORTANT DATES

- Open Enrollment for Qualified Health Plans officially starts November 1, 2024. Your group benefits administrator will provide additional information to you when your organization's Open Enrollment will actually start.
- Any changes typically made during Open Enrollment in the months of November and December will take effect on January 1, 2025.
- Every organization may set their own Open Enrollment period, but must start after November 1, 2024. Your employer will share those dates with you.

PLAN RESOURCES

Choosing a health plan may be challenging if multiple options are available. Below are resources to help with this process. If you have any questions, contact us or your group benefits administrator.

WEBSITE AND BLOG

Check out our blog for helpful health and wellness articles at **bluecrossvt.org/blog**. We also have a dedicated resource page for groups at **bluecrossvt.org/QHP-groups-resources.**

HOW COST-SHARE WORKS

Based on your selected plan, we cover a share of health care costs. This typically includes office visits, hospital care, and medications. Cost-share does not include premiums or costs associated with non-covered services.

We begin paying 100 percent of the costs for covered services when you reach your plan's maximum out-of-pocket limit. To understand what your out-of-pocket costs may be, please see our plans and premiums chart or the plan's Summary of Benefits and Coverage (SBC).

To help understand terminology about your plan, we have a glossary available on page 7.

DEDUCTIBLE TYPES

We have two different deductible types, stacked and aggregate. Members enrolled in an employee-only plan are not impacted, but if a family member is added onto their plan at a later date, it will change how the plan pays benefits. Below is an explanation of the two deductible types.

Stacked – Once an individual meets their deductible or out-of-pocket limit, the plan pays accordingly even on a two-person or family plan.

Aggregate – The full deductible or out-of-pocket limit must be met collectively by members on the plan before benefits are paid. Depending on the out-of-pocket limit, there may be plans that set a specific individual out-of-pocket maximum which limits expenses paid by an individual in a calendar year.

The benefits for each are different based on enrollment in an employee-only, two-person, or family plan.

UNDERSTANDING PRESCRIPTION DRUG COSTS

It is important to understand how prescription drug benefits work for each plan and your potential cost for your medications. With the NPF formulary, medications are assigned to three different tiers: generic, preferred brand, and non-preferred brand. Costs may vary for each tier level on each plan.

Our plans and premiums chart details each plan's pharmacy benefits available to you and the costs. If you take a brand name drug, talk to your provider or pharmacist to see if there are generic alternatives that might work for you. Once you are a member, if you are still concerned about the cost of the prescription, talk to Vermont Blue Rx℠ to see what other options may be available to you.

MANAGING COSTS WITH A HEALTH SAVINGS ACCOUNT

In addition to offering health coverage, an employer may provide a health savings account to pair with your health plan. If they do, your employer will provide you with details on how the account will work.

A Health Savings Account (HSA) is a tax-free savings account you can use to pay for IRS-approved medical expenses, both those covered by your health plan and items that are not. You must be enrolled in a Consumer-Directed Health Plan (CDHP) to contribute money into an HSA. There is a limit on the amount you can contribute toward an HSA in a year.

If you are enrolled in a CDHP, talk with your local financial institution about opening an HSA if not supplied by your employer. You will be responsible to add money into the account, like a normal savings account and typically the vendor will provide a debit card for making payments easy. You may not be able to deduct money from your paycheck pre-tax for contributions, but if you add money, you'll receive a tax form at the end of the year to help submit your taxes.

Note, if your employer offers a Health Reimbursement Arrangement (HRA) in addition to your Blue Cross VT health plan, you may not be eligible to fund an HSA.

You can also learn more about HSAs, annual contribution limits, or view the list of qualified medical expenses, visit **bluecrossvt.org/MyMoney**.

COST COMPARISON TOOL

As a member, you can estimate the cost of services before you go to your provider. Members can locate the tool in the Member Resource Center (MRC) at **bluecrossvt.org/MRC**.

LOCAL SUPPORT

At any time, you can contact us for support. Whether you need help with your plan benefits, comparing plans, or have general questions, our Vermont-based team is always ready to help you.

(800) 255-4550 | **(TTY/TDD: 711)**

consumersupport@bcbsvt.com

We are available Monday through Friday 8 a.m. to 4:30 p.m.

NEXT STEPS: AFTER YOU'VE ENROLLED

Once enrolled in a health plan with us, follow these three simple steps:

1 KEEP AN EYE ON THE MAIL

Whether you are new member to Blue Cross VT or a returning member, we will send you and your covered family members new ID cards in the mail. You will need your new ID card(s) to access medical services, and to fill a prescription at the pharmacy or set up mail-order services.

During Open Enrollment, ID cards will be mailed in December for January 1 coverage. If you are joining your employer plan during the middle of the year, ID cards take about 10-14 business days to arrive.

We will also mail you an Outline of Coverage highlighting your plan and provide a detailed summary of your benefits.

2 REGISTER ONLINE FOR OUR MEMBER RESOURCE CENTER

Once you receive your new ID card(s), register online to access the Member Resource Center (MRC) at **bluecrossvt.org/MRC**.
Only your Blue Cross VT ID card is needed to register! By registering, you have more visibility of your health plan, coverage, claims activity, and more.

- View plan benefits and incurred expenses.
- View claims to check on the payment status and any amount you may owe.
- View plan materials including proof of coverage, outline of coverage, and order replacement ID card(s). All members can request hard copies, by contacting our customer service team at the number listed on the back of your ID card.

3 CONNECT WITH US

Throughout the year, we have community events that you can participate in from Apple Days to Snow Days and Mountain Days, all completely free for you to enjoy. Our website and social media accounts are great ways to learn about our upcoming events. We also have a great library of educational and informative blog articles. If you want to hear from us regularly, be sure to sign up for our member newsletter too.

Community Events: **bluecrossvt.org/community**

Blog: **bluecrossvt.org/blog**

Newsletter sign-up instructions: **bluecrossvt.org/MRC**

Follow us on social media: @bluecrossvt

ABOUT BLUE CROSS VERMONT & OUR HEALTH PLANS

ABOUT US

For more than 40 years, we have been the state's only local, non-profit health plan, supporting the health and wellness of Vermonters. We are not just a health care company; we are your friends and neighbors. We are dedicated to supporting you, our partners, and communities, not just today, but tomorrow and for years to come.

When you have a Blue Cross VT health plan, you have:

- Coverage from a trusted, local, Vermont non-profit organization
- Support from staff located in Vermont
- Award-winning Vermont-based customer service
- Access to the largest network of doctors and hospitals in Vermont, around the U.S. and globally
- Free, local events and informative blog articles found on **bluecrossvt.org/health-community**

Contact us. We're here to help.

(800) 255-4550 | (**TTY/TDD: 711**)

consumersupport@bcbsvt.com

Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186

GLOSSARY

Allowed Amount:
The agreed-upon cost for the services, drugs, or supplies delivered by a member's pharmacist or doctor.

Coinsurance:
The share of medical cost a member is responsible to pay after their deductible has been met. For example, if a member has a 20% coinsurance, their health plan pays 80% of the cost, and the member pays 20%.

Copayment:
The amount a member pays for specific health care services at the time of care. A member will either pay coinsurance or copayment and is determined by their health plan.

Cost-Share:
The amount a member pays when receiving medical services, hospital services, and pharmacy services. These amounts include any combination of the following type of payments: deductibles, copayments, and coinsurance.

Deductible:
The dollar amount a member pays for services and/or medications before their plan begins to pay a larger portion of their costs.

Formulary/Drug Lists:
A list of prescription costs, both generic and brand name, covered by a member's plan.

Out-of-Pocket Limit:
The maximum amount a member will pay for covered services during a plan year.

Premium:
A member's monthly payment for their health plan coverage.

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