Open Enrollment 2019

Understanding the Difference Between the VEHI Plans

Necessary Form

Election Form

– If not electing for the current year, please fill in name at top and sign at the very bottom to waive participation –

Employer Name (Please Print) _____ Payroll Effective Date _____

Employee Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Home Phone ( ) _____ Work Phone ( ) _____

Employee Email Address _____

I hereby authorize and direct my employer to reduce my earnings in the amount necessary to fund my Cafeteria Plan as indicated below. I understand such reductions, considered elective contributions under the Plan, will start with my first paycheck dated after the plan year begins. I understand that the purpose of this program is to allow employees to select qualified benefits within the guidelines of the Internal Revenue Code. I also understand that the flexible spending account plan(s) will allow me to be reimbursed for eligible out-of-pocket medical, dental, vision and/or dependent care expenses.

☐ I choose to participate in Flexible Spending Account (FSA) elections.

Health FSA – Medical Expenses ..... $ _____ (Annual Amt.) (Max. $2,650)

DCAP – Dependent Care (Child Care) Expenses ..... $ _____ (Annual Amt.) (Max. $5,000)

☐ I choose the debit card for my payment method.

I understand that the debit card is restricted to certain merchant categories and is not accepted at all Mastercard® acceptance locations. I understand that I may not obtain a cash advance with the debit card at any merchant, bank or ATM. I understand that the debit card is to be used exclusively for Qualified Expenses as defined by the plan(s) in which I participate. If the debit card is issued pursuant to Employer Plans and I use the Card for an expense that is not a Qualified Expense I am indebted to my Employer and must repay the full amount of the non-qualified expense. I agree to save all invoices and receipts related to any expenses paid with the debit card; upon request I must submit these documents for review by my benefits administrator. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and I will be required to remit payment to my Employer. Payment may be in the form of an offsetting claim, personal check, electronic draft from my personal checking or savings account, a post-tax deduction from my paycheck, or other options established by my employer.

Additional Card Requested: Name on 2nd Card (cannot be same as Employee) _____

☐ I choose Direct Deposit for my payment method.

Routing Transit Number
(All 9 boxes must be filled)
☐☐☐☐☐☐☐☐☐

Account Number
(Include hyphens, but not spaces or special symbols)
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

_____ ATTACH A VOIDED CHECK HERE _____
DO NOT attach a Deposit Slip because deposit slips often do not show all the needed information

I understand this salary reduction agreement will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in my family status. I hereby certify the above information to be correct and true and I choose to participate.

Signature _____ Date _____

OR I choose not to participate in the FSA for this plan year.

Signature _____ Date _____

DataPath Administrative Services, Inc.
1601 Westpark Drive • Suite 9 • Little Rock, AR 72204 • 501-801-5317 • Toll-Free 866-207-3028 •
Fax 501-553-9099 • Toll-Free Fax 855-504-3457 • Email: vtsupport@datapathadmin.com

Break Down

- All employer contributions are based on the Gold CDHP plan
- For teachers – 80% of the premium of the Gold CDHP plan can be used towards the plan of your choice
- For support staff – 90% of the premium of the Gold CDHP plan can be used towards the plan of your choice

- The total employer contribution toward the HRA is also based on the Gold CDHP Plan
- For teachers – Total for a family plan is $4,500; single plan $2,000
- For support staff – total for a family plan is $4,750; single plan $2,250

Comparison Grid

VEHI Health Plans
FY19 Rates

VEHI Plan Comparison Grid

Type of Service	VEHI Platinum	VEHI Gold	VEHI Gold- CDHP*	VEHI Silver - CDHP*
	Deductible / Maximum	**Deductible / Maximum**	**Deductible / Maximum**	**Deductible / Maximum**
Medical Deductible (Self/Other than Self)	$500 / $1,000 Stacked^	$1,200 / $2,400 Stacked^	$1,800 / $3,600 Aggregate**	$3,000 / $6,000 Stacked^
Prescription Drug Deductible	$0	$0	Included in Medical	Included in Medical
Medical Out-of-Pocket-Maximum (Self/Other than Self)	$1,500 / $3,000	$1,800 / $3,600	$2,500 / $5,000	$4,000 / $8,000
Prescription Drug Out-of-Pocket-Maximum (Self/Other than Self)	$1,300 / $2,600	$1,300 / $2,600	$1,350 / $2,700	$1,350 / $2,700
Total Out-of-Pocket Maximum for both Medical and Prescription Drug Benefits (Self/Other than Self)	$2,800 / $5,600	$3,100 / $6,200	$2,500 / $5,000	$4,000 / $8,000
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Preventive Care	$0	$0	$0	$0
Primary Care Office Visit	$25	$25	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Mental Health / Substance Abuse Office Visit	$25	$25	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Specialist Office Visit	$35	$35	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Urgent Care	$75	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Ambulance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Durable Medical Equipment	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Emergency Room	$250	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Radiology (MRI, CT, PET)	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Outpatient	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Inpatient	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Vision Exam	$20	$20	$20	$20
Prescription Drug Benefits	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Wellness Drugs #	n/a	n/a	100%	100%
Generic Tier 1	$4	$4	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Generic Tier 2	$10	$10	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Preferred Brand	$20	$20	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Non-Preferred Brand	50%	50%	deductible, then 20% coinsurance	deductible, then 20% coinsurance
Compatible with: **Health Reimbursement Arrangement (HRA) - ◊** **Health Savings Account (HSA) - •**	◊	◊	◊ •	◊ •

Below is the FY 19 pricing of the VEHI health plans. Rates have been filed and approved by the VT Department of Financial Regulation to take effect July 1, 2018 through June 30, 2019.

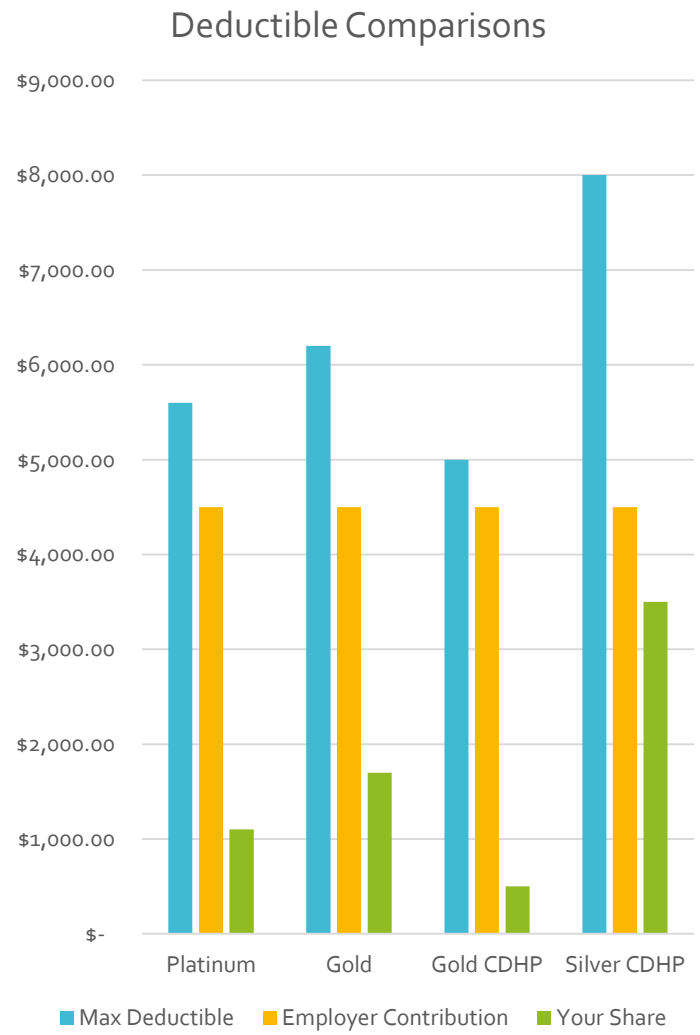
FY 19 Rates	VEHI Platinum	VEHI Gold	VEHI Gold- CDHP*	VEHI Silver - CDHP*
Single (Self)	$699.34	$671.34	$576.11	$534.65
2-Person	$1,398.69	$1,342.68	$1,081.95	$1,069.31
Parent/Child(ren)	$1,169.40	$1,123.53	$890.68	$901.28
Family	$1,978.43	$1,900.39	$1,595.82	$1,521.45

*CDHP- Consumer Directed Health Plan
^Stacked- Plan pays for an individual once the individual deductible is met.
**Aggregate- Full single or entire family deductible must be satisfied before benefits are paid.
#Wellness Drugs- www.bcbsvt.com/wellnessrx

Updated 5.23.18

Comparisons - Deductibles

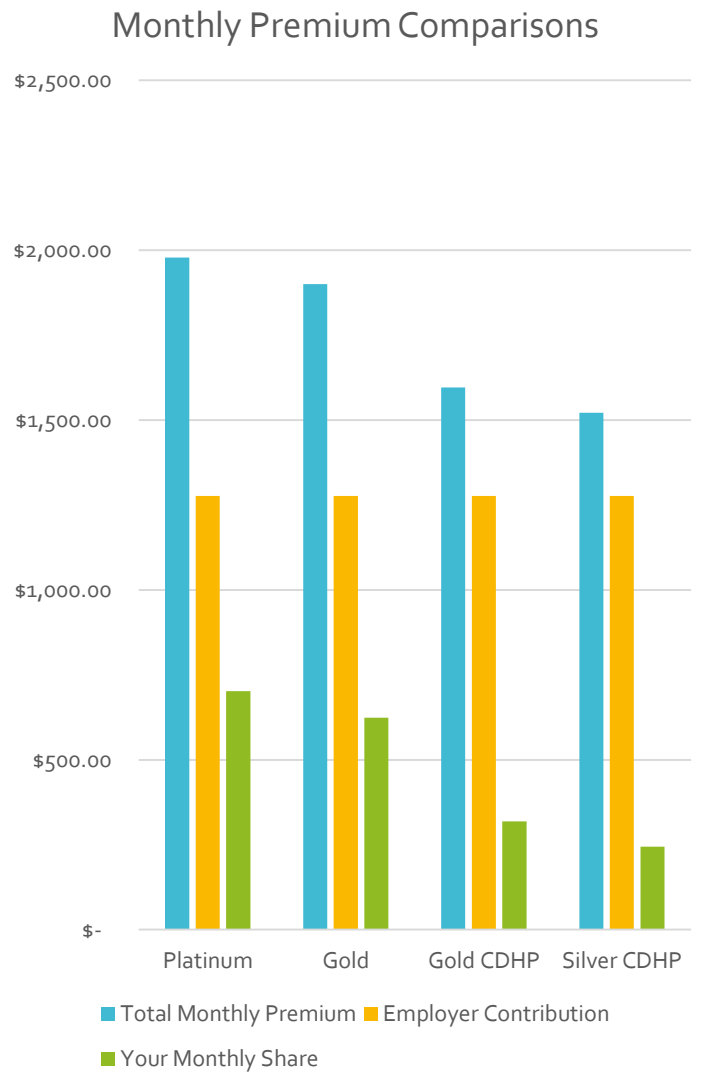
	Platinum	Gold	Gold CDHP	Silver CDHP
Max Deductible	$ 5,600.00	$ 6,200.00	$5,000.00	$ 8,000.00
Employer Contribution	$ 4,500.00	$ 4,500.00	$4,500.00	$ 4,500.00
Your Share	$ 1,100.00	$ 1,700.00	$ 500.00	$ 3,500.00



*data representative of teacher rates

Comparisons – Monthly Premium

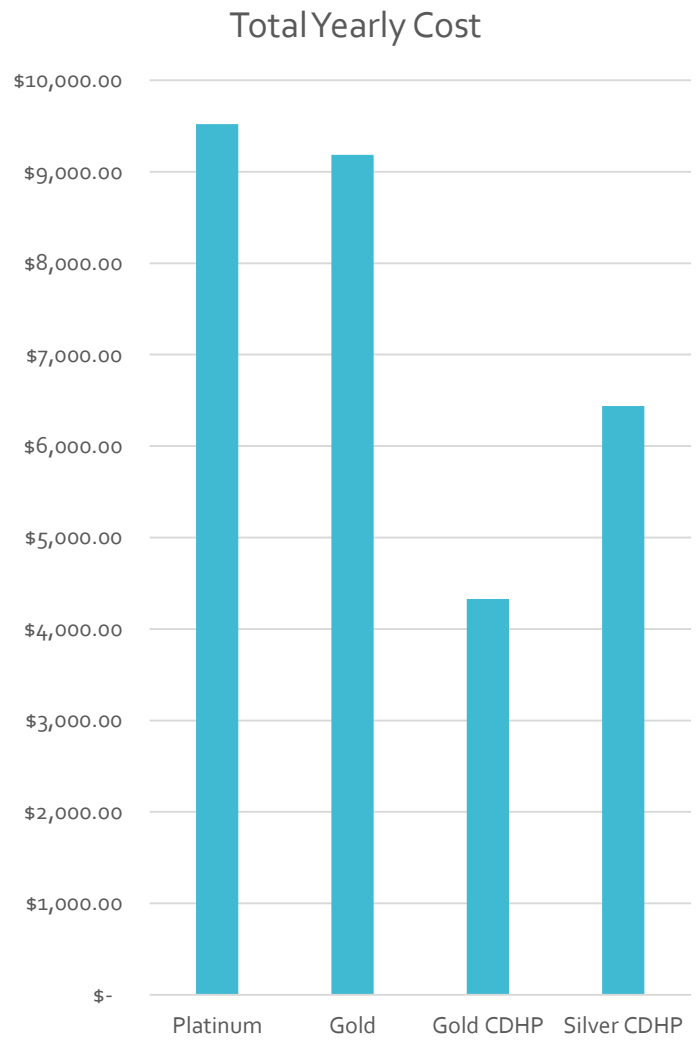
	Platinum	Gold	Gold CDHP	Silver CDHP
Total Monthly Premium	$ 1,978.43	$ 1,900.39	$1,595.82	$ 1,521.45
Employer Contribution	$ 1,276.66	$ 1,276.66	$1,276.66	$ 1,276.66
Your Monthly Share	$ 701.77	$ 623.73	$ 319.16	$ 244.79



*Data representative of teacher rates

Comparisons – Total Yearly Cost

	Platinum	Gold	Gold CDHP	Silver CDHP
Total Yearly Cost	$ 9,521.24	$ 9,184.76	$4,329.97	$ 6,437.48



*Data representative of teacher rates

Contact for Guidance

- If you need help choosing between the four plans and which would work best for your family and needs, please contact Blue Cross Blue Shield. They will be able to look at your prior claims and talk to you about upcoming medical needs.
- (800) 247- 2583

DataPath Update

- Behind their original estimated timeline for reprocessing all claims since January 1.
- So far $800,000 of claims have been found for payment.
- They have 25,000 claims that have been flagged as exceptions - have to be manually processed (estimating two weeks).
- If you are have missing claims, please fill out the form on the last page of the update posted on website at in service and send to me.

PATH/Wellness

- Reminder that there is a Healthy Life Survey that will earn you 60 points when you take it in October!
- Garmin Program – looking to see interest for a discounted Garmin Program. Please contact me if you are interested in this program.
  - Must have a PATH account
  - Must take Healthy Life Survey by the end of October
  - Must sign up for Keeping Fit
  - Must sign up for an Adventure
- For more info about the PATH program, please contact your building leaders: Andrew, Molly, Barb, Shallen, Lynn