2022

Benefits Policy Guidebook

Home Health & Hospice

The heart and science of medicine.

THE University *of* Vermont HEALTH NETWORK

Home Health & Hospice

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Introduction

As a University of Vermont Health Network employee, you make a difference to our patients and their families by bringing compassion to those in a time of need. UVMHN extends this culture of caring to you and your family by providing a comprehensive and flexible benefits package.

Making good decisions about your benefits–from choosing the coverage that meets your healthcare needs, to determining how much to contribute to your retirement–is essential to getting the most out of every benefit dollar you spend. When considering your benefit options, look beyond the per pay-period costs and consider which plans will provide you and your family the best overall value.

The UVM Health Network has designed the benefit offerings to meet the increasingly diverse needs of our growing employee population. Our broader selection of plans provides more choice - whether you need coverage for just yourself or for an entire family. We seek to support the entire Network community by offering a variety of cost-effective benefit plans.

The University of Vermont Health Network is committed to you and your family's overall health, well-being, and financial protection. We understand that you and your family have unique needs. We invite you to take an active role in making the right coverage decisions for your personal situation.

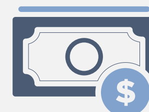
COMMIT TO YOURSELF

Choice gives you flexibility - and with flexibility comes responsibility.

- **You're responsible for taking the time to learn about the different plans available so that you can make an informed decision.**
- **You're responsible for choosing the benefit plans that are the best for you and your family.**

Disclaimer: This guide provides only a brief summary of the benefits available under The University of Vermont Health Network benefit programs. In the event of a discrepancy between this summary and the Plan Document, the Plan Document will prevail. The University of Vermont Health Network retains the right to modify and/or eliminate these or any other benefits at any time for any reason.

OUR APPROACH TO BENEFITS AT UVM HEALTH NETWORK IS TO KEEP THE FOCUS ON YOU AND YOUR FAMILY.

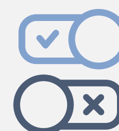


VALUE AND COST

Get the biggest bang for your buck!

ACCESS

Get access to the coverage you need, when you need it and where you need it.



CHOICE

Choose the best option for your needs and preferences.

PROTECTION

Provide basic benefit protection against the financial impact of life events.

COMMUNICATE

Convey information to allow for informed decision making.

SUPPORT

Encourage you to ask questions and seek counseling in decision making.

Eligibility

To participate in Home Health & Hospice benefits, you must be a full-time or part-time employee with scheduled weekly hours between 30-40 hours. We have two types of benefit eligible employment classifications:

- **Full-time Regular**
  Hired to regularly work 30-40 hours per week.
- **Part-time Regular: Hired before April 1, 2014 (Grandfathered)** Regularly work 22.5 or 24 hours per week.

If a temporary employee accepts regular employment, transitioning from a temporary status, they will retain their hire date.

Home Health & Hospice has four employee classifications that are not eligible for benefits (unless noted), and those are:

- **Full-time Temporary Employee**
  Hired to work in a position for a certain period of time, not to exceed 1 year, and regularly working 30-40 hours per week.
- **Part-time Regular: Hired on or after April 1, 2014 (Non-Grandfathered)** Regularly work 29 hours or less per week.
- **Part-time Temporary Employee**
  Hired to work in a position for a certain period of time, not to exceed 1 year, and regularly working 29 hours or less per week.
- **Per Diem, Hourly**
  Hired to work on an irregular, as needed basis for an indefinite period of time.

Please see Employee Handbook for more information.

ENROLLMENT

Enrollment in most plans at Home Health & Hospice is made via Workday. As a general rule, your elections under our plans should be made on a prospective basis (when possible) and cannot be changed until the beginning of the next calendar year.

Because you pay for benefits with pre-tax dollars, the IRS requires that your benefit elections be permanent for the plan year. Once elected, you can only change your benefits if you have a qualifying life event Benefit election changes as a result of a qualifying event must meet certain guidelines and must be made within an allowed time period. Benefit election changes as a result of a qualifying event must meet certain guidelines and must be made within an allowed time period.

If you miss your enrollment deadline, you will receive only employer paid life insurance, short-term and long-term disability, and Employee Assistance Program (EAP) coverage.

WHEN IS COVERAGE EFFECTIVE

ANNUAL OPEN ENROLLMENT

Enrollment and changes made during Open Enrollment (annually in November) are effective January 1 of the next year. Payroll deductions for most plans begin with the first paycheck in January.

HIRE OR BENEFIT ELIGIBILITY DATE

When you are hired or first move into a benefit eligible classification, your coverage will begin the first of the month following your date of hire. If your hire date or benefit eligibility date is the 1st of the month, your benefits begin that day.

You have 31 days to enroll in coverage following your start date or benefit eligibility date.

Regardless of when you enroll within those first 31 days, your coverage will begin on the 1st of the month, even if that date has passed. You

are responsible to pay for coverage from your coverage effective date.

EXAMPLE:

- **Hire Date**: January 20
- **Time to Enroll in Coverage**: January 20 - February 20 (31 days)
- **Coverage Begins**: February 1
  If you complete your enrollment after February 1, your benefits will still begin February 1 and you will be responsible for any missed premiums payments.

ELIGIBLE DEPENDENTS

YOU CAN ELECT TO COVER THE FOLLOWING DEPENDENTS IN BENEFITS:

- Spouse
- Legally Dependent Child up to age 26
- Disabled Dependents of any age

Home Health & Hospice requires that you provide documentation for any dependents you wish to cover under its benefit plans. Below is a list of eligible dependents with appropriate documentation that can be provided to validate their eligibility. Documentation should be scanned and uploaded within Workday for review and approval.

If you elect benefits that include coverage for dependents, please add their Social Security number(s) (SSNs) in the space provided during enrollment in Workday. It is important to provide this information, as the Affordable Care Act (ACA) requires employers to report to the IRS the SSNs of all physicians and dependents with coverage.

FOR ANNUAL OPEN ENROLLMENT:

Documentation must be provided before the start of the new calendar year.

HIRE OR BENEFIT ELIGIBILITY DATE:

Documentation must be provided within 31 days.

You can only be covered once under a UVM Health Network benefit plan. If your spouse or child(ren) are already covered under a UVMHN benefit plan, you will not be able to add them to coverage under your plan.

FOR EXAMPLE:

- If your spouse works at UVMHN or an affiliate and covers you under their medical plan, you cannot elect medical.
- You can only be covered by one medical plan at UVMHN.
- You can, however, cover yourself and family on medical coverage and then have your spouse cover you and your family under dental coverage.

ELIGIBLE DEPENDENTS	Documentation Required For Coverage
Your Legally Married Spouse	Marriage Certificate **or** Copy of the 1st page of last year's Federal tax return, indicating "Married Filing Jointly" or "Married Filing Separately"
YOUR LEGALLY DEPENDENT CHILD(REN) UP TO AGE 26 REGARDLESS OF MARITAL STATUS INCLUDING:	
Biological Child	Copy of Birth Certificate or Application for a Birth Certificate
Legally Adopted Child	Adoption Record **or** Placement for Adoption document from Court
Stepchild (through marriage)	Copy of your Marriage Certificate **and** Child's Birth Certificate
Child whom you or your Spouse are Legal Guardians	Court Order **or** Legal Guardianship Document
Unmarried Child age 26 or older who is disabled and incapable of self support	Birth Certificate **and** Request for Coverage for an Adult Dependent Due to Disability Form completed by dependent's health care provider

PAYING FOR COVERAGE

Home Health & Hospice Plans follow Section 125 of the Internal Revenue Code, which allows you to pay for and fund their health coverage (medical, dental, vision, flexible spending accounts, and health savings accounts) on a pre-tax basis. In other words, you do not have to pay FICA tax or state and federal income taxes on the earnings that are deducted to pay for and fund these benefits.

In order for Home Health & Hospice to offer coverage to be paid on a pre-tax basis, we must follow specific enrollment requirements. Some of these requirements include keeping physicians enrolled through the calendar year, only providing coverage for eligible dependents, and only allowing changes to coverage when they have a qualifying life event.

QUALIFYING LIFE EVENTS ALLOWING BENEFIT CHANGES

IRS QUALIFYING LIFE EVENT	Life Event Examples	Who can enroll/ unenroll	Deadline to Request Change in Coverage	Coverage Start or End Date of Coverage	Timeline Examples
Annual Open Enrollment	1 time per year opportunity to elect, drop, or change benefits	Employee Spouse Dependent(s) of Employee	Enrollment is in November. Elections must be made prior to start of the new year.	January 1	Open Enrollment: 11/15 - 11/30 Effective Date of Coverage: 01/01
A Loss of eligibility for other coverage	• Employment Change (you or your spouse) • Divorce or Legal Separation • Child becomes an ineligible dependent due to age (includes turning 26 and losing coverage through a parent) • Death of Spouse	Employee Spouse Dependent(s) of Employee	31 days after loss of coverage	First of month following loss of coverage	Loss of coverage: 02/15 Enrollment window: 02/15 - 03/15 Effective date of coverage: 03/01
Gain of coverage under another qualified health plan	Gain of coverage through spouse (includes election of coverage as a new hire or annual enrollment)	Employee Spouse Dependent(s) of Employee	31 days after gain in coverage elsewhere	End of month in which coverage is obtained	Date of gaining coverage: 03/01 Enrollment window: 03/01 - 04/01 Effective date of coverage ending: 02/28
Marriage	Getting Married (includes gain of dependents through Marriage)	Employee Spouse Dependent(s) of Employee	31 days after marriage	First of month following marriage	Date of Marriage: 03/10 Enrollment window: 03/10 - 04/10 Effective date of coverage: 04/01
Change in Family Status	• Birth of Child • Adoption or Placement for Adoption • Legal Guardianship Appointment	Employee Spouse Dependent(s) of Employee	60 days after change in Family Status	Date of change in Family Status Action required to add child beyond 60 days to benefits.	Date of Birth: 05/05 Enrollment window: 05/05 - 07/05 Effective date of coverage: 05/05 Charges for coverage would not begin until 07/05
Loss of Premium Assistance Subsidy	Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP)	Employee, who is eligible but not enrolled Dependent(s) of Employee	60 days after loss of coverage	First of month following loss of eligibility	Loss of eligibility: 07/15 Enrollment window: 07/15 - 09/15 Effective date of coverage: 08/01
Gaining Premium Assistance Subsidy	Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP	Employee, who is eligible but not enrolled Dependent(s) of Employee	60 days after eligibility for a premium assistance subsidy is determined	First of month following gain in premium assistance	Gain of Subsidy: 09/22 Enrollment window: 09/22 - 11/22 Effective date of coverage ending: 09/30

- Documentation supporting each of these IRS Qualifying Events (except Open Enrollment) is required in order to begin or end coverage under UVM Health Network.
- The benefit changes you request must be consistent with your life or family status change.

How to Enroll in your Benefits

1. **REVIEW YOUR BENEFIT OPTIONS.**
   Review this guide and utilize our online resources to determine your benefits eligibility. Decide which options work best for you and your family.

2. **GATHER YOUR INFORMATION.**
   If enrolling for the first time or adding new dependents to your benefits coverage, you will be required to provide their date of birth, Social Security number, and a copy of your dependent documentation. You will need to upload a copy of your dependent documentation into Workday within 31 days.

3. **ENROLL THROUGH WORKDAY.**
   Workday is UVM Health Network's web-based human resources, payroll, and benefits system.

   For help using the Workday system, review the link for step-by-step guides or contact the HR Solution Center at (844) 777-0886.

4. **PRINT.**
   Please review your final elections carefully before submitting, and remember to print and/or save a copy for your records.

5. **FOLLOW UP WITH REQUIRED DOCUMENTATION.**
   If dependent verification documentation and/or life status change supporting documentation is required, please upload these documents to Workday within 31 days if you did not attach the documents at the time of enrollment. (If documentation is not received within the 31-day time frame, your dependent(s) will be removed from coverage.)

   Evidence of Insurability (EOI) may also be required for life insurance coverage. If you receive an email from The Hartford regarding EOI, please complete within 60 days to ensure your coverage is not denied for insufficient information.

6. **REVIEW YOUR PAYCHECK.**
   It is always important to review your paycheck and ensure your benefit deductions and pay are accurate.

NEED HELP UNDERSTANDING YOUR BENEFITS?

THE HUMAN RESOURCE SOLUTION CENTER IS YOUR FIRST STOP FOR QUESTIONS PERTAINING TO BENEFITS.

- Hours:
  Monday – Friday, 8am – 5pm
- Email:
  HRSolutionCenter@UVMHealth.org
- Phone: (844) 777-0886
- UVMHN Benefit Website

QUESTIONS REGARDING YOUR PAYCHECK, KRONOS,

OR TAX WITHHOLDING?

PAYROLL IS AVAILABLE TO HELP ANSWER YOUR QUESTIONS.

- Hours:
  Monday – Friday, 8am – 4:30pm
- Email:
  Payroll@UVMHealth.org
- Phone:
  (802) 847-3760
- Intranet

Medical Insurance

UVM Health Network will offer four medical plans to meet your and your family's needs. Regardless of the plan you enroll in, all plans utilize the same network of providers. This means that regardless of the plan you choose, you will have access to the same providers, hospitals, and facilities.

Blue Cross Blue Shield (BCBS) is our medical plan administrator. With more than 95% of physicians and 96% of hospitals in the BCBS national network, you have convenient access to providers, services, and in-network rates wherever you are.

All plans allow you to seek care without a referral for both in and out-of-network care. You will save money by utilizing UVMHN Providers and Facilities. If you utilize a non-participating BCBS provider or facility (out-of-network) your out-of-pocket expenses will be higher.

NATIONAL BCBS NETWORK

Within each of our four plans, we have three tiers of coverage:

- **UVMHN Providers and Facilities**
  Any providers or facilities within The University of Vermont Health Network. All UVMHN providers and facilities are contracted with BCBS. Domestic services have the lowest cost-share.
- **BCBS Providers and Facilities**
  Providers and facilities are providers BCBS has contracted with under your health coverage. In-network does not mean a provider or facility needs to be located in Vermont or New York. BCBS provides network coverage nationally.
- **Non-participating BCBS Providers and Facilities**
  Refers to any providers or facilities that have not contracted with BCBS. When utilizing out-of-network care you will be responsible for a higher percentage of cost-share.

When you select UVMHN providers and facilities, your money goes further because a greater portion of your care is covered by the plan. Refer to the medical plan chart for an overview of coverage and out-of-pocket costs for medical care.

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms. Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change. Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

BENEFIT PROVIDED BY:
Blue Cross Blue Shield

CONTACT INFORMATION:
(833) 578-1126

GROUP NUMBER:
71-5940Q

WEBSITE:
myhealthtoolkitvt.com

WEBSITE FEATURES:

- Access Plan Information
- Order a new ID Card
- View Explanation of Benefits

PLANS OFFERED:

Visit the UVMHN Benefit Website to access the Summary of Benefits & Coverage (SBC) documents for each Plan.

- UVMHN - 250 Plan
- UVMHN - 400 Plan
- UVMHN HDHP with HSA Plan – 1500
- UVMHN HDHP with HSA Plan - 3000

COVERAGE LEVELS:

- 1 Person
- 2 Person
- Family

OTHER HELPFUL DOCUMENTS:

- BCBS Preventive Care Link
- Coordination of Benefits Form

REGARDLESS OF THE PLAN YOU ENROLL IN, PREVENTIVE CARE IS COVERED AT 100%

UVMHN 250 & UVMHN 400 PLAN

You **do not** need to designate a Primary Care Physician (PCP), if you enroll in the 250 or 400 Plan. You may go outside of the provider network for health care services however, you will pay less if you use doctors, hospitals, and other health care providers that belong to the BCBS Network.

Under the UVMHN 250 and 400 Plan, co-pays apply for most office visits and prescription drugs. Certain outpatient services and all inpatient care will apply towards the deductible and coinsurance. Examples of these services include scans, inpatient stays, blood or lab work outside preventive care.

UVMHN 1500 & 3000 HDHP WITH HSA

HDHP utilizes the same network as the lower deductible plans. Like the lower deductible plans, you **do not** need to designate a PCP.

All services, with the exception of preventive care visits and some preventive medication, apply toward the deductible and coinsurance. There are no co-pays on this plan. This means if you have a doctor's visit or need a prescription that is not considered preventive, the cost of the visit and the script would apply towards the deductible.

The UVMHN HDHP with HSA –Plans offer a unique feature not available with the other medical plans. When you enroll in these plans, you receive a UVMHN Health Savings Account (HSA) contribution based on the plan you choose and who you cover. You will always own this account along with any money that is contributed to it.

EMBEDDED VS. AGGREGATE DEDUCTIBLE

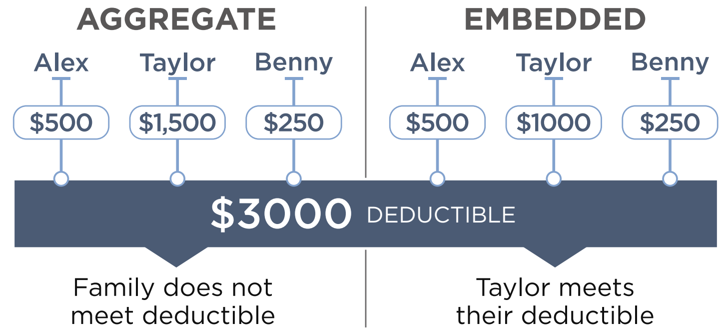
With an aggregate family deductible, your family will be paying the deductible until the entire family deductible is collected. With an embedded family deductible, the plan begins to make payments as soon as one member of the family has reached their individual deductible. IRS guidelines specify that in a qualified HDHP, individual deductibles do not apply.

FITZ FAMILY:

- $3,000 Deductible

MEDICAL BILLS THIS YEAR:

- Alex: $500
- Taylor: 1,500
- Baby Benny: $250



	PREFERRED-PROVIDER ORGANIZATION (PPO)		HIGH DEDUCTIBLE HEALTH PLAN (HDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)	
	UVMHN 250 PLAN	UVMHN 400 PLAN	UVMHN HDHP WITH HSA PLAN – 1500	UVMHN HDHP WITH HSA PLAN – 3000
Providers/Network	UVMHN, National BCBS, and Non-Participating BCBS Providers and Facilities			
Co-pays	Yes, office visits and prescription drugs		Only for some preventive drugs	
Deductible	Embedded		Aggregate	
Deductible: In-Network	Single: $250 Family: up to $750	Single: $400 Family: up to $1,200	Single: $1,500 Family: $3,000	Single: $3,000 Family: $6,000
Out-of-Pocket Max: In-network	Single: $1,500 Family: up to $4,500	Single: $1,700 Family: up to $5,100	Single: $5,000 Family: $10,000	Single: $6,000 Family: $12,000
Deductible: Out-of Network	Single: $500 Family: up to $1,500	Single: $800 Family: up to $2,400	Single: $3,000 Family: $6,000	Single: $6,000 Family: $12,000
Out-of-Pocket Max: Out-of-Network	Single: $2,000 Family: up to $6,000	Single: $2,300 Family: up to $6,800	Single: $5,000 Family: $10,000	
Eligibility: Health Savings Account (HSA) or Flexible Spending Accounts (FSA)	General Purpose FSA	General Purpose FSA	Limited Purpose FSA and HSA	Limited Purpose FSA and HSA
Employer Funding	n/a	n/a	Single: $500 Family: $1,000	Single: $1,000 Family: $2,000
Notes: All plans provide cross-accumulation of in and out of network deductibles and coinsurance.				

BENEFIT PLAN	UVMHN 250 & 400 Plan			UVMHN HDHP with HSA - 1500 & 3000 Plan		
For Deductible and Out-of-Pocket Information, please see previous page.						
Network	**UVMHN Providers**	**BCBS National Providers & Non-UVMHN Providers**	**Out-of-Network Providers**	**UVMHN Providers**	**BCBS National Providers & Non-UVMHN Providers**	**Out-of-Network Providers**
General Medical Expenses						
Preventive Care (includes annual physical and other age-based screenings)	100% covered			100% covered		
Primary Care Office Visit	100% covered	$10 co-pay	After deductible, 30% coinsurance, up to out-of-pocket max	10% after deductible, up to out-of-pocket max	20% after deductible, up to out-of-pocket max	30% after deductible, up to out-of-pocket max
Outpatient Mental Health & Substance Use Visit						
Specialist Office Visit	$25 co-pay					
Chiropractic Care (20 visit limit per calendar year)						
Acupuncture (12 visit limit per calendar year)						
Maternity Office Visits	$10 co-pay	$25 co-pay				
	Any scans or sonograms require deductible and coinsurance.					
Outpatient Care						
Outpatient Physical, Speech, Occupational Therapy	100% covered	$25 co-pay	30% after deductible, up to out-of-pocket max	10% after deductible, up to out-of-pocket max	20% after deductible, up to out-of-pocket max	30% after deductible, up to out-of-pocket max
Outpatient Lab and X-ray		10% after deductible, up to out-of-pocket max				
Outpatient CT/MRI/Nuclear Scans	5% after deductible, up to out-of-pocket max					
Outpatient Surgery						
Physician and Facility Fees						
Emergency Services						
Emergency Room Facility	$50 co-pay (waived if admitted)			10% after deductible, up to out-of-pocket max	20% after deductible, up to out-of-pocket max	30% after deductible, up to out-of-pocket max
Urgent Medical Care	$25 co-pay					
Inpatient						
Hospitalization (includes maternity delivery & newborn services, labs and scans)	5% after deductible, up to out-of-pocket max	10% after deductible, up to out-of-pocket max	30% after deductible, up to out-of-pocket max	10% after deductible, up to out-of-pocket max	20% after deductible, up to out-of-pocket max	30% after deductible, up to out-of-pocket max
Residential Treatment Facility (mental disorders, alcoholism, or drug abuse)						
Other Benefits						
Routine Eye Exam (1 visit every 2 calendar years)	100% covered must use VSP Provider		not covered	100% covered must use VSP Provider		not covered

BCBS Participating Providers will:

- Bill directly for your services, so you don't have to submit a claim.
- Not ask for payment at the time of service, except for deductible, coinsurance, or co-payments.
- Accept BCBS Allowed Price as full payment (you do not have to pay the difference between their total charge and BCBS Allowed Price). Non-participating BCBS providers may bill you for any balance remaining after BCBS pays the Allowed Price.

Prescription Coverage

Pharmacy benefits are included in all UVMHN Health Insurance Plan Designs. Prescription coverage requires medical plan enrollment. Medical and prescription coverage cannot be separated.

Navitus Health Solutions processes and pays prescription drug claims for UVMHN employees. Navitus has a strong commitment to improving your and your family's health, while minimizing your out-of-pocket costs.

PHARMACY NETWORK

You pay the lowest amount for your medication when you fill it through the UVM Health Network Retail or Mail Pharmacy. Often, there is no out-of-pocket cost. Your payment will be higher if you fill your prescription through any participating pharmacy. You will pay 50% of the cost of prescriptions filled at pharmacies that are not in the network.

There are more than 64,000 retail network pharmacies covered under Navitus. Local pharmacies such as CVS, Kinney Drugs, Rite Aid, Hannaford, Shaws, Price Chopper, and Walgreens are covered under the Navitus network.

COVERAGE

All covered prescriptions are categorized into one of three cost-sharing levels. Level 1 contains most generic drugs (least expensive) whereas Levels 2 and 3 contain most brand-name drugs. Review the **Navitus Formulary List** to determine which level your prescription drugs fall into. The most current list may be found at www.navitus.com (after login).

PREVENTIVE DRUG LIST

Navitus has developed a list of generic drugs that are used in the prevention of various medical conditions. For example, some of these medications may be prescribed for treatment of high blood pressure, diabetes and high cholesterol. The drugs on the Preventive Drug List will either be provided at no cost or will require a co-pay, regardless of which medical plan you are enrolled in.

SPECIALTY PRESCRIPTIONS

EXCLUSIVELY FILLED AT UVMHN SPECIALTY PHARMACY

Injectable drugs and other specialty medications have become a vital part of treatment for complex diseases such as multiple sclerosis, rheumatoid arthritis and cancer.

Prescriptions for specialty medications must be filled at The UVM Health Network Specialty Pharmacy. If UVMHN Specialty Pharmacy cannot provide your prescription, they will coordinate with you to secure the prescription you need. These drugs can be picked up or mailed to your home address.

BENEFIT PROVIDED BY:
Navitus Health Solutions

CONTACT INFORMATION:
(866) 333-2757

GROUP NUMBER:
NVUVMA

WEBSITE:
Navitus.com

ONLINE ACCESS:

Navitus provides online access through the "Navitus Member Portal." Within the Member Portal, you can:

- Find your drug cost and out-of-pocket expenses
- Find the location of an in-network pharmacy near you.
- Find information on how to request a formulary exception for a non-covered drug

OTHER HELPFUL INFORMATION:

- Member Claim Form
- Navitus Formulary
- Preventive Drug List

MEDICAL PLAN	UVMHN 250 & 400 Plan		UVMHN 1500 & 3000 HDHP with HSA	
Preventive Drugs	Covered as a co-pay based on formulary tier.		Certain Preventive Drugs are covered as a co-pay based on formulary tier.	
Pharmacy	**Network Pharmacy**		**Co-pays Apply After Deductible** Network Pharmacy	
UVMHN Retail/Mail Order	**30-Day Supply**	**90-Day Supply**	**30-Day Supply**	**90-Day Supply**
Tier 1	$0	$0	$0	$0
Tier 2	$25	$50	$25	$50
Tier 3	$45	$90	$45	$90
Navitus Retail Pharmacy				
Tier 1	$10	$30	$10	$30
Tier 2	$30	$90	$30	$90
Tier 3	$50	$120	$50	$120
Non-Participating Pharmacy				
All Tiers	Covered at 50%		Not Covered	

AN EXAMPLE OF HOW AN HDHP WORKS

Under the 1500 HDHP and 3000 HDHP, you will be responsible for the cost of any care, services, or prescriptions up to the deductible. After meeting the deductible, you will pay coinsurance for medical care and services. A co-pay will apply for any prescriptions after the deductible is met.

EXAMPLE:

You have a 25 minute office visit with your Internal Medicine Provider, you will pay the BCBS negotiated rate. This amount will apply to the deductible.

- Cost of Visit:..$197
- BCBS Negotiated Rate: $151
- **Out-of-pocket Expense to you, applied to deductible: $151**

EXAMPLE:

If you have an MRI of your abdomen at a UVM Health Network Facility, you will get the BCBS negotiated rate. This amount will apply to your deductible and once that is met, you will pay coinsurance.

- Cost of Visit:..$4,032
- BCBS Negotiated Rate: $3,526
- **Out-of-pocket Expense to you: $1,702.60**
- (Assumes single coverage under the $1,500 Plan with no other expenses in the calendar year)
- Deductible $1,500
- Coinsurance...$202.60

EXAMPLE:

You are prescribed a medication that is not preventive that costs $327 for a 30-day supply.

- Cost of Prescription: $327
- **Out-of-pocket cost, paid for by you. This applies to deductible:........................... $327**

NOTE:

SEPARATE ID CARDS ARE ISSUED BY BCBS AND NAVITUS.

Choosing a Health Plan for You and Your Family

Choosing a health plan can be overwhelming and confusing. There are a lot of things to consider and while we are not permitted to provide specific guidance or recommend a health plan, we can help you understand the options you have. We want to ensure you feel informed and can make the best decision for you and your family.

WHAT IS THE SAME ABOUT THE FOUR MEDICAL PLANS?

- **Blue Cross Blue Shield will provide medical coverage for all plans. The national BCBS network applies to all plans. How you pay for care and services you receive will vary depending on plan enrolled.**
- **Navitus is the prescription carrier. The prescription formulary, or list of drugs covered by Navitus, is the same for all plans. The cost when picking up a prescription will vary depending on plan enrolled.**
- **Preventive care is covered at 100%.**
- **You will have the lowest cost share when utilizing UVMHN providers. In-network coverage will apply anytime you use a BCBS provider that is not part of UVMHN. You also have the ability to utilize an out-of-network provider but your deductible and coinsurance will increase, resulting in paying the most out-of-pocket for care.**

THINGS TO CONSIDER WHEN CHOOSING A PLAN

COMPARE OUT-OF-POCKET COSTS

1. **Annual Premiums:**
   What will you pay out of your paycheck for coverage under each plan?

2. **Current Utilization:**
   Consider your current utilization by reviewing your Explanation of Benefits (EOB) from BCBS. Through BCBS's website, the Member Resource Center, you can access your and your family's medical claims history. Navitus' website can provide any prescriptions history for you and your family.

3. **Make sure you understand Health Terms:**
   When looking at your past claims history and plan designs, it is important to make sure you understand terms like allowed amount, co-pay, deductible, coinsurance and out-of-pocket maximum.

4. **Compare Current Utilization to Various Plan Designs:**
   When looking at the allowed pricing from previous claims, what would you pay under a different plan design? Would expenses be applied to the deductible and coinsurance? These expenses can be added to the premiums to provide a total medical plan expense.

5. **Upcoming Care:**
   While we can't predict the future, it is important to consider any care you may have in the foreseeable future. Things to consider are major surgeries, common procedures or medications you take. You can then see how that care would be applied to your out-of-pocket expenses.

   - When utilizing the BCBS or Navitus website, you can estimate costs for common procedures as well as medications costs near you. Keep in mind, if you visit a UVMHN provider, the cost of the service will be lower than what is shown on the BCBS website.

THINGS TO CONSIDER WHEN CHOOSING A PLAN

CONSIDER YOUR RISK TOLERANCE

WOULD YOU RATHER HAVE HIGHER PREMIUMS

(via your paycheck) but pay less at the time you utilize care through lower co-pays, deductible and coinsurance?

- This could be a good option for you and your family if you prefer a consistent budget or utilize the health plan quite a bit.

WOULD YOU RATHER PAY LESS IN PREMIUMS

(via your paycheck) but pay more at the time you access care and take advantage of a tax-free Health Savings Account (HSA)?

- This could be a good option for lower utilizers of health care services and prescription coverage, or those that are looking to save money, tax free, for future medical expenses.
- An HSA provides you the ability to save money, earn interest/invest, and use the money tax free for qualified expenses through the rest of your life.

DECISION SUPPORT TOOL

UVMHN recognizes there are a lot of things to consider when choosing a Medical Plan for you and your family. With that in mind, UVMHN has implemented a Decision Support Tool, called PLANSelect, to help provide you guidance.

HOW DOES IT WORK

PLANSelect is available from any computer or mobile device. Personal information is not collected, but you will be asked to enter your zip code and answer four questions to help predict your upcoming expenses.

- Who do you plan to cover on your plan?
- How much do you typically use your plan?
- What medical events do you anticipate in the next year?
- What medical conditions do you or anyone you plan to cover currently have?

PLANSelect uses your responses and zip code to calculate your need for medical services like office visits, prescriptions, surgeries, and lab work. UVMHN Medical Plan designs have been loaded into the tool and the cost of services is estimated based on national actuarial tables and regional data.

After completion, you are provided with a recommendation on which of the 4 UVMHN medical plans would likely provide the best value and be the lowest overall cost to you. Once the recommendation is provided, the information doesn't stop there.

PLANSELECT IS INTENDED TO:

- Provide clarity on your options – taking into account your premiums, out-of-pocket expenses, and HSA employer contributions.
- Explain why the recommendation is the best choice for you.
- Reduce the stress in choosing the right plan.
- Provide insight into the value of your benefits.

Click on this link to access the decision support tool, PLANSelect.

Spending and Savings Accounts

FSA & HSA

The Flexible Spending Accounts (FSA) and Health Savings Account (HSA) plan administrator, HealthEquity, will help you manage your accounts and claims processing. HealthEquity provides many convenient services such as:

- **Online Account Management**
  Check account balances, set-up direct deposit for claim payments, and order additional debit cards for your dependents.
- **Online Claims Management**
  File new claims, review pending claims.
- **Comprehensive Educational Materials and Planning Tools**
  Calculators for annual elections, and tax savings potential, and lists of eligible and ineligible expenses.
- **Mobile App to manage your Account**
  Same services available as web.
- **24/7 Customer Service**

FLEXIBLE SPENDING ACCOUNT GENERAL, LIMITED PURPOSE AND DEPENDENT CARE

OVERVIEW & ELIGIBILITY

Flexible Spending Accounts (FSA) allow you to take money out of your paycheck on a pre-tax basis to pay for eligible expenses for you, your spouse, and/or any eligible dependents.

When you enroll in an FSA, you decide how much to contribute to the account for the entire calendar year. The money is deducted from your paycheck pre-tax (before federal and state income taxes and FICA taxes are deducted) in equal amounts. By doing this, you reduce your taxable income and increase your take-home pay by the amount of your tax savings. Your tax savings depends on your tax bracket.

USING THE MONEY

HealthEquity provides 3 ways for you to use the money in your account.

- **Pay by Debit Card**
  Card is available for general purpose FSA and Health Savings Account (HSA) only.
- **Pay Me Back Claim**
  If you have already paid for an expense out-of-pocket, you can pay yourself back by submitting documentation. Payment is issued by direct deposit or check to your home address.
  - This is the best option to use for Dependent Care FSA.
- **Pay My Provider Option**
  Pay your healthcare providers directly from your account for eligible expenses.

BENEFIT PROVIDED BY:
HealthEquity
(formerly WageWorks)

CONTACT INFORMATION:
(877) 924-3967

GROUP NUMBER:
26018

WEBSITE:
healthequity.com

PLANS OFFERED:

- Flexible Spending Account (FSA)
  - General Purpose
  - Limited Purpose
  - Dependent Care
- Health Savings Account (HSA)

CONTRIBUTIONS:

Pre-tax contributions from your paycheck for all FSAs and HSA

UVMHN provides employer contributions for the HSA

OTHER HELPFUL INFORMATION:

- Eligible Expenses
- FSA Guide
- Dependent Care Guide
- HSA Guide
- Investing your HSA

GENERAL PURPOSE FSA ELIGIBLE EXPENSES

Pre-tax funds can be used for:

- **Co-pays, deductible, coinsurance**
- **Medical, Dental, and Vision out-of-pocket expenses**
- **Hearing Aids**
- **Some over the counter items such as lens cleaner, band-aids, and sunscreen**

LIMITED PURPOSE FSA ELIGIBLE EXPENSES

Pre-tax funds can be used for:

- **Dental and Vision out-of-pocket expenses**
- **Some over the counter items such as lens cleaner**

LIMITED PURPOSE FUNDS CANNOT BE USED FOR MEDICAL EXPENSES.

CARRYOVER BENEFIT - GENERAL & LIMITED PURPOSE FSA

You may carryover up to $570 of unused funds into the next plan year. The carryover amount doesn't count towards your annual contribution maximum. Any unused funds greater than $570 will be forfeited after the last day of the run-out period. The run-out period (January 1–May 31) provides you additional time to submit claims that were incurred during the plan year for reimbursement. If you have more than $570 in your account at the end of the year, you will lose it.

EXAMPLE:

Let's say you have $800 remaining at the end of the plan year (December 31, 2021). You have until May 31, 2022 to submit for any expenses incurred in 2021. If you do not have any expenses from 2021, $570 will carry over into the next plan year (2022). The remaining $230 will not carry over.

CONTRIBUTIONS - GENERAL & LIMITED PURPOSE FSA

General and Limited Purpose FSAs allow you to contribute up to $2,850, in 2022, for eligible expenses for you, your spouse, and/or any eligible dependents.

Your annual election is available to you on your first day of coverage, which means that when you incur eligible expenses, you can use your debit card or submit for reimbursement immediately even though the money you set aside is deducted from each paycheck, little by little over the course of the year.

EXPENSES PAID USING YOUR HEALTHEQUITY DEBIT CARD MAY REQUIRE PROOF OF YOUR EXPENSE(S).

Keep all receipts and/or Explanation of Benefit forms. HealthEquity will notify you if itemized receipts or additional documentation is required to validate your purchase.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

OVERVIEW & ELIGIBILITY

A Dependent Care FSA is a pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camps, before and after school programs, and child or elder daycare.

Eligible dependents include your children under the age of 13. Other eligible dependents include an adult child, an adult relative, or your spouse, provided that the adult dependent is physically or mentally incapable of self-care. Eligible dependents must rely on you for more than 50% of their financial support for the calendar year and they cannot qualify as a dependent of any other person.

DEPENDENT CARE FSA ELIGIBLE EXPENSES

PRE-TAX FUNDS CAN BE USED FOR:

- **child care**
- **before or after school programs**
- **elder care (in your home or someone else's)**
- **senior daycare**

For the most up-to-date listing of eligible expenses under a Dependent Care FSA, visit the HealthEquity website or IRS.gov for Publication 503.

It is important to compare this option with the child and dependent care tax credit. Visit IRS.gov for more information.

Under a Dependent Care FSA, your contributions can be used for expenses that allow you to work. To be eligible dependent care must meet the following requirements:

- **Care is provided to allow you to work, look for work, or attend school full-time. This applies to a spouse as well.**
- **Care must be provided by a relative or non-relative at least 19 years old by the end of the tax year.**
- **Care cannot be provided by the child's parent or another tax dependent.**
- **Your care provider conforms to state and local laws and is able to provide you with their Social Security or Tax ID number. This will be required when filing Form 2441 with your federal income tax.**

CONTRIBUTIONS – DEPENDENT CARE

A Dependent Care FSA allows you to contribute up to $5,000, if you are an individual or married filing jointly. If you are married and filing separately you can contribute $2,500.

Funds in your dependent care FSA are available as you contribute them to your account. Unlike the other FSAs, you pay out of pocket, then receive reimbursement based on how much you have withheld from your paycheck for dependent care expenses. A debit card is not provided with a dependent care FSA.

GRACE PERIOD – DEPENDENT CARE

While there is no carryover for Dependent Care FSA, there is a grace period. The grace period provides additional time for you to use the funds remaining in your account. You have until March 15, 2023 to incur expenses that can be paid for using funds remaining from the 2022 plan year.

EXAMPLE:

If you have $300 remaining at the end of the plan year (December 31, 2021), those funds will remain available for you to use for eligible expenses until March 15, 2022.

You have until May 31, 2022 to submit those 2021 eligible expenses for reimbursement.

Health Savings Account

(HSA)

Employees who enroll in either a UVMHN HDHP with HSA Plan will have a Health Savings Account (HSA) automatically opened on their behalf with HealthEquity.

A Health Savings Account or HSA is a tax-advantaged personal savings account that works with the HDHP. It allows you to set aside money to pay for eligible health care expenses. The account is yours to own and manage on your own. If you retire or leave employment, you'll take this account with you along with any contributions from your employer. There's no "use it or lose it" rule with your HSA. The money remains in the account until you decide to spend it.

HEALTH SAVINGS ACCOUNTS OFFER A TRIPLE TAX ADVANTAGE BY MAKING THE FOLLOWING TAX FREE:

- **Contributions**
- **Anytime you use money for qualified expenses for you or any of your tax dependents**
- **Any Interest or Investment Earnings**

HDHP enrollees will need to ensure that they meet the HSA eligibility requirements, outlined to the right, before enrolling in an HSA.

CONTRIBUTIONS

In 2022, UVMHN will make a contribution to your HSA help you lower your out-of-pocket costs and save more. Then, you can make pre-tax contributions from your paycheck to build your savings to pay for health care now or in the future. The UVMHN HSA contribution is based on the plan you choose and who you cover. UVMHN's contribution and your HSA savings are always yours to keep or use toward health care expenses.

UVMHN will deposit half of their contribution in January and the remaining contributions will be evenly distributed in April, July, and October. Newly hired employees will receive prorated amounts.

UVMHN's contributions to your HSA, plus any contributions you make may not exceed the yearly maximum.

See the Appendix for more details.

DO YOU QUALIFY?

Participating in one of the HDHPs qualifies you for an HSA, but IRS rules may make you ineligible or affect the tax status of your account.

DO YOU QUALIFY TO PARTICIPATE IN A HEALTH SAVINGS ACCOUNT (HSA)?

- Are you on any form of Medicare or collecting Social Security?
- Do you have non-high deductible medical insurance coverage outside of UVMHN?
- Does your spouse have a Flexible Spending Account (FSA)?

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, YOU ARE NOT ELIGIBLE TO PARTICIPATE IN AN HSA.

You are eligible to participate in a Flexible Spending Account (FSA). Regardless of your HSA eligibility, you can still be enrolled in a High Deductible Health Plan.

HSA CONTRIBUTION LIMITS	UVMHN HDHP with HSA Plan – 1500		UVMHN HDHP with HSA Plan – 3000	
	Single	**Family**	**Single**	**Family**
UVMHN Contribution	$500	$1,000	$1,000	$2,000
Your Contribution	Up to $3,150	Up to $6,300	Up to $2,650	Up to $5,300
Total Contribution allowed by the IRS	$3,650	$7,300	$3,650	$7,300
If you will be 55+ by end the of the calendar year, you can contribute an additional $1,000 to the total noted above.				

ENROLLMENT

When you enroll in the UVMHN HDHP with HSA Plan – 1500 or the UVMHN HDHP with HSA Plan- 3000, UVMHN sets up on your behalf an HSA account through HealthEquity. This process occurs automatically with your enrollment in the plan. You will receive an ***HSA Welcome Kit*** along with your debit card from HealthEquity.

ELIGIBLE EXPENSES

You may use your HSA to pay for eligible expenses for your spouse or legal IRS dependents, even if they're not covered under the HSA plan. Examples of eligible expenses include:

- **Medical and dental plan deductibles, copays and coinsurance**
- **Prescription drug expenses**
- **Certain over-the-counter drugs with a prescription**
- **Un-reimbursed medical expenses from chiropractic visits and acupuncture for yourself and your dependents**
- **Dental expenses, including braces for you or your dependents**
- **Vision expenses, including Lasik eye surgery**
- **Long-term care expenses and insurance**
- **Cobra premiums**

USING YOUR ACCOUNT

The debit card you receive from HealthEquity may be used to pay for eligible claims. While you do not have to substantiate purchases made with your HSA debit card, it is recommended that you keep all receipts in the event of an IRS audit.

INVESTMENT OPTIONS

One of the key benefits of the HSA is the ability to invest the funds to help maximize your asset and long term savings potential, tax free. Once your account reaches a balance of $1,000, you have the option to invest your HSA funds above that $1,000 balance. For more information on your investment options, fees, and more visit HealthEquity's website.

HOW AN HSA HELPS YOU SAVE FOR RETIREMENT

An HSA can be a resource to help you reach your retirement goals. It combines many of the attributes you find in a traditional IRA and Roth IRA including tax-deductible contributions, tax-free growth and tax-free distributions. If you are able to pay for some or most of your annual health care expenses out of pocket, or if your annual HSA contributions are more than your expenses, the money in your account will accumulate. This money rolls over from year to year and grows tax-free through any investment returns it may earn. You can use this money to pay for qualified health care expenses in the future, including medical expenses in retirement.

DON'T FORGET YOU OWN AND ARE RESPONSIBLE FOR YOUR HSA

AS AN HSA OWNER, YOU:

- **Decide the amount to contribute to the HSA for each calendar year**
- **Arrange for the withdrawal of any excess contributions**
- **Determine how funds in your HSA will be spent and/or invested**
- **Declare whether the distributions from your HSA are taxable or non-taxable.**

You cannot delegate these responsibilities. As an HSA owner you are responsible for reporting all contributions and distributions to the IRS on your Form 1040. If you make any errors and do not correct them them in a timely manner, you may pay additional tax and/or penalties to the IRS. Questions should be directed to your tax advisor.

SPENDING AND HEALTH SAVINGS ACCOUNT OVERVIEW - See Appendix for full comparison.

	General Purpose FSA	Limited Purpose FSA	Health Savings Account	Dependent Care FSA
Health Plan you can be enrolled in	Preferred Provider 250 Preferred Provider 400	1500 HDHP with HSA 3000 HDHP with HSA	1500 HDHP with HSA 3000 HDHP with HSA	n/a
Eligibility to Enroll	Can be used by anyone, however you cannot be enrolled in a HDHP to utilize.	Can be used by anyone if you are under age 65 and enrolled in a HDHP. You cannot be enrolled in a General Purpose FSA.		Anyone can enroll regardless of medical plan. This plan is for child and elder care.
What other Accounts can i enroll in?	Dependent Care FSA	Health Savings Account Dependent Care FSA	Limited Purpose FSA Dependent Care FSA	Healthcare FSA Limited Purpose FSA Health Savings Account

Dental Coverage

Caring for your teeth and keeping your smile healthy can help ensure the rest of your body stays healthy. Benefit eligible employees are able to choose from three voluntary dental plan options through Northeast Delta Dental – Basic, Core and Buy-up.

NETWORK

Delta Dental PPO plus Premier combines two networks of providers and gives you even more options.

- **The PPO network**
  or preferred provider option, provides you access to a network of dentists who accept reduced fees for covered services, giving you the lowest out-of-pocket expenses.
- **The Premier network**
  is a fee-for-service plan that offer the largest network of dentists. These dentists have agreed to contracted fees with Delta Dental, so for covered services, you pay no more than your deductible and coinsurance.

UTILIZING A NON-PARTICIPATING PROVIDER

If you visit a dentist that does not participate in Delta Dental's network, you may be required to pay for services at the time they are provided and submit a claim for the services. Contact Delta Dental for more information or visit their website at nedelta.com.

Please note: Payment for treatment from a non-participating provider will be limited to the dentist's submitted charge or Delta Dental's allowance for non-participating providers in the geographic area where services are provided, whichever is less. Any difference in cost will be your responsibility to pay the dentist.

ENROLLMENT AND UTILIZING COVERAGE

Two ID cards will be issued after your initial enrollment. Both cards are in your name and can be used by anyone you have enrolled in your coverage. If you need new cards at any time, you can access and print electronic versions through nedelta.com.

PREDETERMINATION OF BENEFITS

Northeast Delta Dental recommends that you ask your dentist to submit a pre-treatment estimate for any services involving costly or extensive treatment plans. This will help you understand what out-of-pocket expenses you may incur.

BENEFIT PROVIDED BY:
Northeast Delta Dental

CONTACT INFORMATION:
(800) 832-5700

8:30am - 5pm
MONDAY – FRIDAY

GROUP NUMBER:
7407

WEBSITE:
nedelta.com

PLANS OFFERED:

- Basic
- Core
- Buy-up

COVERAGE LEVELS:

- 1 Person
- 2 Person
- Family

PREMIUMS:

- Cost Share – You and UVMHN
- Pre-tax from your paycheck

OTHER HELPFUL INFORMATION:

- Double-up Maximum Carryover Benefit
- Health through Oral Wellness Summary
- Hearing and Vision Discount

DENTAL COVERAGE OVERVIEW

BENEFIT PLAN	Description	Basic	Core	Buy-up
WAITING PERIOD	**There is no waiting period for services. Coverage is effective on the first day your coverage becomes active.**			
NETWORK	2 Networks of Providers: PPO - Dentists who have agreed to accept reduced fees for covered services, in turn minimizing your out-of-pocket expenses. Premier - Dentists under a fee-for-service arrangement, providing the largest network of dentists.	Delta Dental PPO Plus Premier		
DEDUCTIBLE	Applies to Coverage B & C noted below.	$50 per person/ $150 per family	$25 per person/ $75 per family	$15 per person/ $45 per family
DIAGNOSTIC & PREVENTIVE CARE (COVERAGE A)	Diagnostic: Oral Evaluations and x-rays Preventive: Up to 4 cleanings per calendar year, fluoride for children up to age 19, Emergency Palliative Treatment	100%	100%	100%
BASIC (COVERAGE B)	Fillings, routine extractions, root canal, treatment of gum disease, denture repair	80%	80%	80%
MAJOR (COVERAGE C)	Crowns, dentures, implants, surgical extractions, removable and fixed partial dentures (bridge)	50%	50%	60%
ANNUAL BENEFIT MAXIMUM (PER PERSON ENROLLED)	Calendar year maximum Delta Dental will pay towards coverage A, B, C per person covered under the plan.	$1,000	$1,500	$1,500
DOUBLE - UP MAX BENEFIT MAXIMUM	During a calendar year, if you have less than $500 in claims and receive an oral exam/ cleaning, then $250 will carry over and be available for use in future years.	n/a	Up to $3,000	Up to $3,000
ORTHODONTICS COVERAGE	Correction of crooked teeth for children ONLY on the Basic Plan. Adults and children are covered under the Core and Buy-up Plans.	50%	50%	65%
LIFETIME MAXIMUM FOR ORTHODONTICS	Per person enrolled under the plan. Note: The Basic Plan only covers orthodontia for children up to age 19.	$1,000	$1,500	$2,500

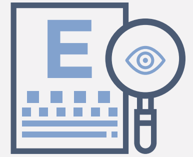
HEALTH THROUGH ORAL WELLNESS (HOW)

Northeast Delta Dental provides an innovative Health through Oral Wellness program (HOW) that works with your dental benefits to achieve and maintain better oral wellness. HOW is based on your specific oral health risk and needs.

FOR MORE INFORMATION AND TO REGISTER, VISIT HEALTHTHROUGHORALWELLNESS.COM.

- Once registered, you can take a quick assessment, which you can share with your dentist at your next visit.
- The dentist can discuss the results and perform a clinical version.
- Depending on your risk, you may be eligible for additional preventive benefits.

Vision Coverage



Vision benefits are designed to help reduce the cost of eyeglasses, contact lenses, and other vision services for you, your spouse, and any dependent children. UVMHN has partnered with Vision Service Plan (VSP) to provide you access to affordable care and quality eyewear.

While you, the employee, must be covered under any vision coverage elections you make, you can choose to cover only the people in your family who need glasses or contact lenses.

PROVIDERS

Under VSP you can use any provider, but you will save money when you use a VSP Signature Network Provider. When you utilize an in-network provider, all claims are submitted directly to VSP by your provider.

GLASSES & CONTACT COVERAGE AVAILABLE AT COSTCO UNDER THE VSP BUY-UP PLAN

You're eligible for the in-network benefit when you purchase eyeglasses or contacts at Costco Optical. Costco will use their secure, HIPAA-compliant systems to confirm your eligibility and bill VSP directly on your behalf.

Exams offered at Costco are available from an independent optometrist near the optical department. We recommend you verify that the optometrist is a VSP Provider when scheduling an appointment. If the optometrist is not a VSP provider, the out-of-network benefit will be applied to the cost of the exam.

ADDITIONAL DISCOUNTS:

- **Extra $20 to spend on Frames when selecting a Featured Brand**
  Ask Provider for details.
- **Hearing Aid Discounts through TruHearing**
  Hearing loss can have a huge impact on your quality of life.
- **Lasik Surgery**
  Save between 5-15% on laser vision correction at contracted facilities.

BENEFIT PROVIDED BY:
Vision Service Plan

CONTACT INFORMATION:
(800) 877-7195
8am - 10pm

GROUP NUMBER:
12157661

WEBSITE:
vsp.com

PLANS OFFERED:

- Core
- Buy-up

COVERAGE LEVELS:

- 1 Person
- 2 Person
- Family

PREMIUMS:

- Paid for by you
- Pre-tax from your paycheck

OTHER HELPFUL INFORMATION:

- Additional Discounts
- TruHearing

COVERAGE OUTLINE

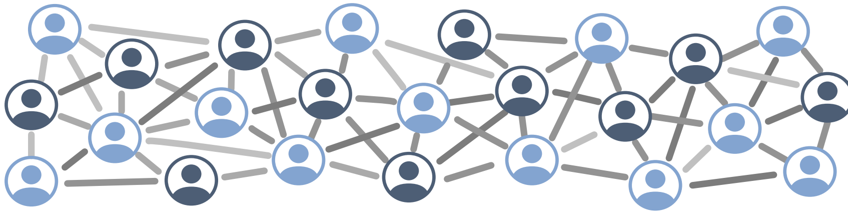
When utilizing your benefit, indicate you have VSP coverage and provide your name and date of birth—there is no ID card for the vision plan. Creating an account via vsp.com will allow you to find a provider, access claim forms if you use out of network provider, and read about other benefits available to you.

VISION COVERAGE OVERVIEW

<table>
<tr><th>NETWORK</th><th colspan="4">VSP Signature
Regardless of plan selected - you must select glasses or contacts. You cannot receive both.</th></tr>
<tr><th rowspan="2">BENEFIT PLAN</th><th colspan="2">Core</th><th colspan="2">Buy-up</th></tr>
<tr><th>Cost</th><th>Frequency</th><th>Cost</th><th>Frequency</th></tr>
<tr><td>EXAM</td><td>$20 co-pay</td><td>Every Calendar Year</td><td>$10 co-pay</td><td rowspan="3">Every Calendar Year</td></tr>
<tr><td>FRAMES</td><td>$130 allowance
$150 allowance for featured frame brands
20% discount on any amount over allowance</td><td rowspan="2">Every Other Calendar Year</td><td>$175 allowance
$195 allowance for featured frame brands
20% discount on any amount over allowance
$95 Costco allowance</td></tr>
<tr><td>LENSES</td><td>Single Vision, Lined Bifocal, and Lined Trifocal
Polycarbonate lenses for dependent children</td><td>Single Vision, Lined Bifocal, and Lined Trifocal
Polycarbonate lenses for dependent children</td></tr>
<tr><td>CONTACTS (INSTEAD OF GLASSES)</td><td>$130 allowance for contacts and contact lens exam</td><td>Every Calendar Year</td><td>$175 allowance for contacts and contact lens exam</td><td>Every Calendar Year</td></tr>
<tr><td rowspan="2">LENS ENHANCEMENT COVERAGE</td><td>Progressive Lenses</td><td>$0 - $160</td><td>Progressive Lenses</td><td>$0 - $160</td></tr>
<tr><td>Discounts on scratch resistance, anti-glare, and tinted lenses</td><td>35% - 40%</td><td>Discounts on scratch resistance, anti-glare, and tinted lenses</td><td>35% - 40%</td></tr>
</table>

Wellness

Taking care of ourselves enables us to take care of others. When we invest in our own wellbeing by engaging in health-promoting behaviors, we are also investing in the wellbeing of our community. Our state of wellbeing is the sum of the activities we engage in each day. Take control of your wellbeing by increasing daily life-giving activities.



To support you in being your best self in 2022, we encourage you to utilize the resources and education available in the UVMHN Wellness Portal. The UVMHN Wellness Portal is centered around supporting you to discover and practice daily routines and activities which reduce stress, promote a sustainable Life-Work balance and, empower you to live a happy and healthy life. You will be able to access the portal from your web browser or the app (Healthy Path) for registration and daily engagement.

THE UVMHN WELLNESS PORTAL WILL BE UNVEILED IN JANUARY.

Headspace For Work

UVMHN is dedicated to the overall health and happiness of its employees- this includes recognition to mental health. Understanding that workplace stress can have a significant impact on your well-being, UVMHN wants to give back to employees and provide you with the tools to mitigate the impacts of stress. UVMHN has partnered with Headspace to provide all of its employees with FREE access to the mindfulness and meditation app Headspace.

ABOUT HEADSPACE FOR WORK

Headspace is an app-based mental health and wellness product proven in studies to cut stress, and to help people sleep, focus, and show up as their best selves at home and work.

UVMHN Employees have access to the entire Headspace library, which includes hundreds of meditation, mindfulness, productivity, and sleep exercises on the app. Exercises range in duration so they can fit into any schedule.

WHY CHOOSE HEADSPACE

Mindfulness has been shown to help people stress less, focus more, and sleep soundly. Headspace is your personal guide to mindfulness. With hundreds of guided exercises for meditation, sleep, focus, and movement, their app can help you start and end your days feeling like your best self.

- **With this free subscription, you have access to:**
  - Guided meditations on stress, self-esteem, relationships, and more
  - Sleep casts, music, and bedtime experiences for good nights and better mornings
  - The Wake Up: a new, bite-sized daily video series designed to make you smile
  - Move Mode: train your body and mind at the same time with quick workout videos, guided cardio, and guided yoga

HOW DO I SIGN UP FOR HEADSPACE?

Look for an email with instructions on how to enroll for free.

IS THERE AN APP AVAILABLE?

Headspace is designed to be accessed anywhere at any time.

Although your initial sign-up should be done from the website, you may download the app on a mobile device to access the program on a daily basis.

OTHER HELPFUL INFORMATION:

Here are a few videos to get you more familiar with what Headspace has to offer.

- Mini Meditation: Letting Go of Stress Video
- Sleepcast: Rainday Antiques
- Move Mode: Wind-down Home Workout

UVMHN hopes that Headspace will bring some more health and happiness to your days — at work, at home, and everywhere in between.

Life Insurance

Benefit eligible employees are provided, at no cost, one time their annual base salary in term life insurance, up to $100,000. In addition to your term life coverage, you are provided one time your annual base salary in Accidental Death & Dismemberment coverage, up to $100,000. You are automatically enrolled in this coverage the first of the month following your benefit eligibility date. There are no health requirements or questionnaires for employer provided coverage.

Your annual base salary is calculated by taking your hourly rate multiplied by your bi-weekly authorized hours, and then multiplying by 26 pay periods. Base salary does not include shift differentials, overtime, supplemental bonuses, or stipends. Once you determine your annual base salary, round up to the nearest thousand to determine the value of coverage. The value of the coverage is also visible within Workday.

> **EXAMPLE OF EMPLOYER PAID LIFE INSURANCE:**
>
> Hourly Rate: $15.00
> Bi-weekly Authorized Hours: 80 hours
> $15.00 x 80 hours x 26 pay periods = $31,200
> Annual Salary is then rounded to nearest thousand = $32,000

In this example, you would be provided $32,000 in term life insurance that would be paid out in the event of your death. If your death was a result of an accident, an additional $32,000 would be paid out.

LIFE INSURANCE AND INCOME TAXES

Since Home Health and Hospice pays for your term life coverage and is considered part of a group life insurance plan, any life insurance coverage exceeding $50,000 is considered taxable income (imputed) by the IRS. Imputed income will be reported on your W-2 as part of your taxable income.

To determine the amount of imputed income – you will need to calculate the coverage over $50,000, use your age at the end of the calendar year, and use the table noted in the Appendix.

In the event this benefit is paid out as a result of your death, the value would not require taxes be paid on the value due to the IRS exemption on group coverage up to $50,000 and the imputed income you pay on the value over $50,000.

BENEFICIARY DESIGNATION

When enrolling in your benefits via Workday, you can elect to designate a beneficiary to your life insurance coverage. In the event of your death, the benefit would be paid out to the individuals noted assuming they are still living.

- **You are not required to designate your life insurance to your spouse, if you are married.**
- **You can designate a trust as your beneficiary as well.**
- **Your beneficiaries can be updated at any time during the year, by updating them in Workday. At a minimum, it is important to review your allocations annually.**

You are automatically the beneficiary for any life insurance coverage for your spouse and/or child(ren).

CARRIER:
The Hartford

CONTACT INFORMATION:
(888) 716-4549

POLICY NUMBER:
0GL889554

WEBSITE:
TheHartfordatWork.com

LIFE INSURANCE PAYMENTS

Additional life insurance is paid for by you on an after-tax basis, so if a benefit is paid out to you or a beneficiary, it will be paid tax-free

ADDITIONAL COVERAGE OPTIONS

Additional Life Insurance coverage for yourself can be purchased in increments of 1, 2, or 3 times your annual salary, up to a maximum of $350,000. This maximum includes the employer paid coverage.

- **Additional life insurance coverage provides you accidental death and dismemberment coverage automatically and mirrors the value of the term coverage as long as the value is the lesser of ten times your annual salary or $350,000.**
  - Accidental death and dismemberment (AD&D) coverage provides financial coverage if there is an unintentional death or dismemberment (loss of use of body parts or functions). Refer to the Summary Plan Description (SPD) for more specific information.
- **Upon becoming eligible for life insurance coverage, you can elect up to $225,000 coverage without completing EOI as long as coverage is elected within the first 30 days of eligibility.**
- **For any amounts above $225,000 or coverage not elected during the first 30 days of eligibility, EOI will be required.**
- **Rates are age-banded and adjust within the month you are born.**
- **Additional benefits under your coverage are Seat Belt and Air Bag Coverage, Repatriation, and Child Education benefits. Refer to the Summary Plan Description (SPD) for more information.**

SPOUSE LIFE INSURANCE

You can elect to purchase additional coverage for your spouse in increments of $5,000 up to $175,000. Coverage is term coverage only.

- **Any coverage you elect on your spouse cannot exceed 50% of the coverage you have on yourself.**
- **Upon becoming eligible for life insurance coverage, you can elect up to $20,000 coverage without completing EOI as long as coverage is elected within the first 30 days of eligibility.**
- **For any amounts above $20,000 or coverage not elected during the first 30 days of eligibility, EOI will be required.**
- **Spouse life insurance includes accidental death and dismemberment coverage.**

CHILD LIFE INSURANCE

Life Insurance for dependent children can be purchased for children up to age 26. Coverage provides a flat $10,000 benefit for each dependent child from live birth up to the age of 26. No EOI is required for child life insurance.

FOR AGE-BANDED RATES AND PREMIUM CALCULATION, PLEASE SEE THE APPENDIX.

EVIDENCE OF INSURABILITY

Additional life insurance coverage may require Evidence of Insurability (EOI). EOI is documented proof of good health, which is completed in the application process for life insurance coverage.

- **EOI will be mailed to your home address for completion.**
- **EOI must be completed within 60 days.**
- **The Hartford will notify you of approval or denial.**
- **Premiums will be deducted from your paycheck and coverage will be visible within Workday.**

AGE REDUCTION

Under The Hartford life insurance policies there is a reduction in life insurance coverage once you reach the age of 65. Your coverage continues; however this means the insurance coverage is reduced by a certain percentages based on your age. This reduction applies to Home Health & Hospice paid coverage as well as any optional coverage you elect for you or your spouse. The reduction is based upon the insured person's date of birth.

- **At age 65, coverage is reduced to 65% of the coverage in place prior to age 65.**
- **At age 70, coverage is reduced to 50% of the coverage in place prior to age 65.**
- **Reduced coverage is rounded to the nearest $500 of coverage, if not already a multiple of $500.**

PORTABILITY/CONVERSION

If you leave UVM Health Network employment or become employed in an ineligible status, you can take the coverage with you. Under The Hartford Life Insurance Plans, you can take your coverage with you by porting or converting coverage. Please be aware you have 31 days to make an election on continuation.

Short-Term Disability

(STD)

Short-Term Disability (STD) is available through The Hartford to full-time employees after completion of six (6) months of continuous service and part-time grandfathered employees. STD provides the employee a portion of their pay when they are out of work for greater than one week (two weeks if grandfathered) for approved non-occupational illnesses/injuries or pregnancy. This benefit is offered at no cost to the employee.

COVERAGE

- After a seven calendar day waiting period, full-time employees (60-80 hours per pay period) with six (6) months of continuous service will receive benefits equal to 60% of base pay for up to a maximum of 25 weeks.
- After a 14 calendar day waiting period grandfathered employees will receive benefits equal to 60% of their standard hours of base pay for up to a maximum of 24 weeks.

REASONS WHY YOU MIGHT NEED DISABILITY

Short-term disability can be used when a healthcare provider has indicated you are unable to perform the essential functions of your job for at least one week. Some of these could include things like:

- **Childbirth**
- **Pregnancy Complications**
- **Surgery with a recovery period at least 1 week in length**
- **Non-work related injury**
- **An illness**

STARTING A CLAIM

Asking to take a leave of absence from work – whether you need time off for a medical procedure or to welcome a newborn into your family – can be stressful to do. It is important to have a conversation with your manager about your need for leave. While you should provide as much advance notice as possible for an upcoming leave, you do not need to provide the reason or details surrounding your need for leave.

Things you should do before a leave:

- **Make your request to your manager in person, if possible**
- **Call The Hartford**
- **Return the Request for Time Away from Work Form to LOA@UVMHealth.org**

BENEFIT PROVIDED BY:
The Hartford

CONTACT INFORMATION:
(888) 310-5615

GROUP NUMBER:
697672

WEBSITE:
www.AbilityAdvantage.TheHartford.com

WEBSITE FEATURES:

- Start a Claim
- Check Claim Status

PLANS OFFERED:

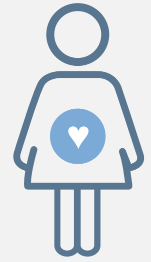
- Short-term Disability
- Long-term Disability

PREMIUMS:

- Paid by UVMHN

MATERNITY LEAVE

Maternity Leave is provided through Short-Term Disability coverage and is available through The Hartford. Disability benefits are paid for up to a maximum of six (6) weeks for vaginal birth and eight (8) weeks for a cesarean section.



Long-Term Disability

(LTD)

Home Health & Hospice will provide Long-Term Disability insurance to designated regular full-time and part-time grandfathered benefited employees. This coverage is administered by The Hartford and will begin the first of the month on or after hire date. Coverage is subject to the terms of the LTD contract and would begin 6 months after a documented disability begins, or as otherwise provided in plan documents in effect at a particular time. LTD insurance provides 60% of your base monthly salary on the date of the approved disability. Maximum monthly benefit is $10,000.

Copies of the LTD contract, the terms of which control over this brief summary, are available and employees should refer all questions regarding LTD to the Human Resources Department.

Please see UVMHN Home Health & Hospice Employee Handbook for more information.

IF YOU ARE ENROLLED IN THE BCBS MEDICAL COVERAGE THROUGH UVMHN, YOU ARE ELIGIBLE FOR THE MATERNITY CARE PROGRAM.

The Maternity Care Program provides information and support during your pregnancy and postpartum period. After completing a short assessment, you will receive access to My Health Planner, an interactive app that guides you through your customized pregnancy program. In addition, you will have a Care Manager who will manage your process and provide support where needed.

To learn more, log into MyHealthToolkitVT.com and access the Maternity section under the Wellness tab or call the Care Management Team directly at (855) 838-5897.

403(b) Retirement Plan

PLAN HIGHLIGHTS

- Employees can contribute to the 403(b) plan immediately by way of Traditional pretax deferrals and Roth after-tax deferrals.
- Automatic enrollment applies after 30 days employment (3% pretax employee deferral).
- Subject to eligibility, Home Health & Hospice may make an annual matching contribution to your 403(b) account. In recent years, Home Health & Hospice has made an annual 100% match on the first 3% of employee contributions. The annual match amount is subject to Board approval.
- Subject to eligibility, Home Health & Hospice may make a discretionary defined contribution to your account. The amount of contribution can vary from year to year. Discretionary contributions are made annually and are subject to Board approval.
- You direct how to invest your contributions. If you make no election, contributions will go to a default investment option based on your age.
- You are always 100% vested in your personal contributions and the earnings on your contributions.
- Home Health & Hospice discretionary, non-elective contributions are subject to a tiered vesting schedule. With each year of eligibility service you earn, you become 20% vested. You are 20% vested with one year, 40% vested with two years, and eventually 100% vested when you've earned your fifth year of eligibility service.
- You are always vested in any Home Health & Hospice matching contributions you receive.
- Contact Fidelity or use their website to manage your contribution amount and your investment selections.

PARTICIPATION

All employees can participate in the 403(b) Retirement Plan immediately. Generally, accounts for new employees are established after the first check is processed.

You may change your contribution amount at any time.

BENEFIT PROVIDED BY:
Fidelity

CONTACT INFORMATION:

FIDELITY RETIREMENT SERVICE CENTER
(800) 343-0860

FIDELITY MEETING RESERVATIONS
(800) 642-7131

GROUP NUMBER:
75931

WEBSITE:
nb.fidelity.com/public/nb/UVMHealth/home

RETIREMENT PLAN:
403(b)

CONTRIBUTIONS:
Cost Share – You and UVMHN

Pre-tax or Post-tax from your paycheck

OTHER HELPFUL INFORMATION:

- Manage Account Online
- Summary Plan Description
- Transfer/Rollover Form

ENROLLMENT, AUTOMATIC ENROLLMENT & OPTING OUT

You may begin contributing to the plan at any time during your first six months of employment. **If you do not take any action, you will be automatically enrolled into the 403(b) Retirement Plan after six months of service**. The pre-tax contribution will be set at 3% of pay. Automatic enrollment applies to all new employees and rehires regardless of employment status (full-time, part-time, per diem).

To begin contributing, or to "opt-out" of automatic enrollment, you will need to make that election with Fidelity. If you are a new Fidelity user, there are two ways to make an election:

1. **Log on to www.netbenefits.com/UVMHealth. Click Register as a New User and follow prompts to establish a user name and password. You will need a code that will be sent to your work email address.**
2. **Call Fidelity at (800) 343-0860.**

If you already have an account at Fidelity, use your existing username and password to access our plan from your dashboard.

EMPLOYEE CONTRIBUTIONS

YOUR CONTRIBUTIONS

You can begin making personal contributions immediately by way of traditional pretax and/or Roth after-tax deductions.

All contributions are made by way of payroll deduction. You pay no federal or state taxes on your before-tax contributions (and earnings, if any) until you receive a distribution from the Plan. Roth contributions are made with after-tax dollars and along with any earnings over time, are exempt from taxes when you take a qualified withdrawal.

You may change your contribution amount at any time. Changes are normally effective in the current or following pay period, depending on when you make the election and when paychecks are prepared by Payroll.

YOUR CONTRIBUTION LIMIT

In 2022, the IRS contribution limit is $20,500.

If you will be 50 or older in 2022, you may make additional catch-up contributions of $6,500. For your convenience, if you meet the age requirement, your contribution limit will automatically be extended to $27,000 for the year.

We will automatically shut off your contributions when you hit the allowed maximum for your age.

If you worked for another employer during the calendar year, it is your responsibility to monitor your total contributions. Contact Benefits for more information.

HOME HEALTH & HOSPICE DISCRETIONARY EMPLOYER MATCHING CONTRIBUTION

Subject to eligibility, Home Health & Hospice may make an annual matching contribution to your 403(b) account. In recent years, Home Health & Hospice has made an annual 100% match on the first 3% of employee contributions. The annual match amount is subject to Board approval.

To be eligible for the matching contribution, you must be employed for at least one year and must work at least 1,000 hours during certain measurement periods. Hours worked includes CTO taken as paid time off.

If you work 1,000 or more hours during your first year of employment, you become eligible for the match beginning with the quarter that follows your anniversary date (January, April, July, and October).

If you do not work 1,000 or more hours in your first year, then your service hours will be measured on an annual plan year basis, beginning with the January 1 that follows your date of hire.

The matching contribution is calculated on an annual basis and typically will post to participant accounts within two months following year-end. If you have otherwise qualified for the match, you do not need to be employed at the time the match is paid.

VESTING

Employer matching contributions are not subject to any vesting service requirements. "Vesting" refers to your ownership of employer contributions. You are immediately 100% vested in any employer matching contributions made to your account.

HOME HEALTH & HOSPICE DISCRETIONARY EMPLOYER NON-ELECTIVE CONTRIBUTION

Subject to eligibility, Home Health & Hospice may make an annual discretionary employer contribution to your account. Historically, this contribution has ranged from zero to 4% of pay. The annual non-elective contribution is subject to Board approval.

To be eligible for the non-elective contribution, you must be employed for at least one year and must work at least 1,000 hours during certain measurement periods. Hours worked includes CTO taken as paid time off.

If you work 1,000 or more hours during your first year of employment, you become eligible for the non-elective contribution effective the earliest of January 1 or July 1 following your anniversary date.

If you do not work 1,000 or more hours in your first year, then your service hours will be measured on an annual plan year basis, beginning January 1 that follows your date of hire.

The non-elective contribution is calculated on an annual basis and typically will post to participant accounts within two months following year-end. If you have otherwise qualified for the contribution, you do not need to be employed at the time the contribution is paid.

Employer non-elective contributions are subject to vesting service requirements. “Vesting” refers to your ownership of employer contributions. Home Health & Hospice uses a tiered vesting schedule for non-elective contributions. As you accumulate Years of Eligibility, the percentage of employer contributions that you own increases. After reaching 5 years of Eligibility, you become fully vested.

VESTING SCHEDULE FOR NON-ELECTIVE CONTRIBUTIONS, BASED ON YEARS OF ELIGIBILITY

- 1 year = 20%
- 2 years = 40%
- 3 years = 60%
- 4 years = 80%
- 5 years = 100%

INVESTMENT OPTIONS

Our plan offers a wide range of investment options designed to meet your specific goals, time horizon and risk tolerance. There are mutual funds for stocks and bonds, a stable value fund, and a money market option. The investment line-up also includes age-based, target date mutual funds.

Experienced investors may be interested in opening a self-directed Fidelity Brokerage Link account to access other mutual funds.

If you do not make investment elections, contributions will be automatically invested in the Plan’s predetermined default account. HHH has selected the T. Rowe Price Target Retirement Life Cycle Funds to serve as the default. Which fund you would default to depends on an assumed retirement date that is based on your age.

REHIRE & SERVICE TIME INFORMATION

If you leave Home Health & Hospice and return within 5 years, you will retain any eligibility and vesting you earned during your previous employment period.

If your break in service exceeds five years, you will need to satisfy eligibility requirements before receiving any employer contributions upon re-employment. You're vesting percentage will be reset to zero.

EDUCATION & CONSULTATIONS

Fidelity hosts frequent on-site visits for one-on-one meetings. **Visit the intranet to view the schedule and make an appointment online at** Fidelity.com/reserve **or you can call (800) 642-7131.**

LEARN MORE & MANAGE

Once you activate your account on NetBenefits, you’ll be able to select investments, view on-demand statements, designate a beneficiary, and access the many educational and planning tools available.

BENEFICIARIES

Your beneficiary is entitled to receive your account balance if you die before the entire account was distributed to you. If you are married, your spouse will automatically be your beneficiary unless you authorize otherwise with the written notarized consent of your spouse. If you have not designated a beneficiary or no beneficiary survives you, then your estate will be the beneficiary. You may designate or change your beneficiary at any time by contacting Fidelity directly by phone at (800) 343-0860 or logging on to NetBenefits®. On the website, you'll find the Beneficiary option under the Profile section on the Summary tab.

RECEIVING MONEY FROM YOUR ACCOUNT

The plan is intended to accumulate funds for your retirement. If you leave before retirement, you may roll over the money to another employer's plan or to an IRA to keep it tax deferred. If you die, your beneficiary will receive your benefits. You have access to your funds while you are still employed by UVMHN at the following times:

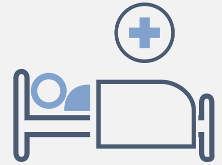
- **Age 59½**
- **You become disabled**
- **You experience a financial hardship**

For more information, please see the Summary Plan Description.

INVESTMENT COMPANIES FORMERLY USED BY THE PLAN, SOMETIMES REFERRED TO AS "LEGACY VENDORS":

- AIG – VALIC
  Group 54143
- Client Care Center
  800-448-2542
  www.valic.com

Voya Voluntary Benefits



You do not need to be enrolled in the UVMHN insurance plans in order to enroll in any of the voluntary plans. You are eligible to enroll in these voluntary plans even if you are covered by another health plan. It is important to note, these plans are not a replacement for your medical insurance.

UVM Health Network has partnered with Voya, a leading voluntary insurance provider, to offer three voluntary benefit options for you and your eligible family members.

Group Pricing
helps make coverage cost effective

Guaranteed-Issue Coverage
with no health questions asked

Payroll Deduction
so you don't have to worry about another bill

HOW DO VOYA VOLUNTARY BENEFIT PLANS WORK?

- **If you or a covered family member experience a covered event following enrollment, you will receive a cash payment based on the plan you are enrolled in and the event you experience.**
- **Your existing medical coverage will process as normal – applying all deductibles and coinsurance as appropriate.**
- **Once you receive an Explanation of Benefits from your insurance carrier, you can submit to Voya for payment directly to you.**
- **You will be responsible for paying your insurance deductibles or coinsurance. The payments that Voya will make to you can be used however you would like. Payments cannot be made directly to your provider for services.**

HOW CAN THESE BENEFITS HELP YOU

Once you submit your claim and it is approved, the benefit you are paid can be used however you like. Benefits are paid directly to you and are in addition to UVMHN's medical and disability benefits. Below are a few examples of how you could use a benefit payment:

- **Deductibles and co-pays for medical care**
- **Child care**
- **Mortgage payment/rent and home maintenance**
- **Everyday expenses like utilities and groceries**

BENEFIT PROVIDED BY:
Voya

CONTACT INFORMATION:
(877) 236-7564

GROUP NAME:
UVM Health Network

POLICY NUMBER:
71743-6

WEBSITE:
Presents.voya.com/EBRC/UVMHN

WHO CAN YOU COVER?

- Yourself
- Your Spouse
- Your dependent children up to age 26, regardless of student status

You, the employee, is required to be enrolled in order to cover a spouse and/or child(ren).

OTHER HELPFUL INFORMATION:

- Accident Coverage
- Critical Illness
- Hospital Indemnity

Accident Insurance

Accident Insurance pays you benefits for specific injuries and events resulting from a covered accident. The benefit amounts depend on the type of injury and treatment received.

You may qualify to receive benefit payments for items listed below, as long as they are a result of a covered accident. Amounts paid are determined by the plan selected (Core and Buy-up), the circumstances of your accident, and the treatment you receive. Examples of covered accidents are:

- Hospital Admission and Confinement
- Urgent or Emergent Treatment
- X-ray
- Lacerations
- Dislocations
- Fractures

Coverage also includes a Sport Accident Benefit, which means if your accident occurs while participating in an organized sporting activity; the benefit amounts associated with accident hospital care, accident care, or common injuries will be increased by 25%; to a maximum additional benefit of $1,000. For a complete description of your available benefits, exclusions and limitations, see your certificate of insurance and any riders.

MEET BEN E. FITZ

Ben is employed by UVMHN and enjoys hitting the slopes in the winter with his family. While on his last run of the day, Ben underestimated his speed and fell breaking his ankle. Below is an example of the benefit he received related to his accident.

COVERED BENEFITS	Core	Buy-Up
Emergency Room Visit	$150	$225
X-ray	$100	$200
Ankle Fracture (non-surgical repair)	$1,200	$2,250
Medical Equipment	$200	$400
Follow-up doctor visit	$60	$100
Physical Therapy (6 visits)	$30	$50
TOTAL PAID BY VOYA ACCIDENT POLICY	**$1,740**	**$3,225**

EXTRA SUPPORT NEXT TIME YOU TRAVEL

In addition to the accident coverage Voya provides Travel Assistance through Europ Assistance USA, at no additional cost.

If you or a covered family member are traveling more than 100 miles from home, Voya Travel Assistance offers enhanced security for your leisure and business trips. You and your dependents can can take advantage of four types of services.

- Pre-trip Information
- Emergency Personal Services
- Medical Assistance Services
- Emergency Transportation Services

PLANS OFFERED:

- Core
- Buy-up

Both plans provide a sport accident benefit.

Critical Illness

Critical Illness Insurance pays a lump-sum benefit if you or a covered family member is diagnosed with a covered illness or condition. Examples include:

- Heart Attack
- Kidney Failure
- Stroke
- Coronary artery bypass
- Cancer

You will have the option to elect two plan options – Core and Buy-up. Benefits paid under the Buy-up Plan will be higher than the Core Plan. The cost of coverage is age-rated and based on your current age, as the employee.

COVERED BENEFITS	CORE	BUY-UP
Coverage Amount		
Employee	$10,000	$20,000
Spouse	$10,000	$20,000
Dependent Child - up to age 26	$5,000	$10,000
Sample of Covered Conditions	**Percentage of Benefit**	
Heart Attack (cardiac arrest is not in itself considered a heart attack)	100%	
Cancer	100%	
Stroke	100%	
Coronary artery bypass	100%	
Kidney Failure	100%	
Additional Covered Conditions	**Percentage of Benefit**	
Severe burns, Benign Brain Tumor, Permanent Paralysis, Loss of sight, hearing, or speech, Coma, Multiple Sclerosis, ALS.	100%	
Bone Marrow Transplant, Stem Cell Transplant, Parkinson's disease, Advanced Dementia (including Alzheimer's Disease), Infectious Disease (hospitalization requirement).	25%	
This is a sample of the benefit coverage, please see the Certificate of Coverage for additional details and information.		

PLANS OFFERED:

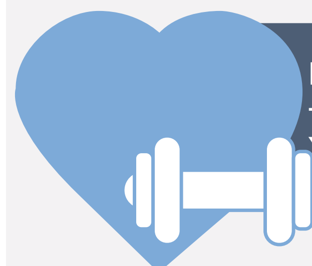
- **Core - $10,000 Benefit**
- **Buy-up - $20,000 Benefit**

Both plans provide a preventive wellness benefit.

WELLNESS BENEFIT

Complete an eligible health screening test, and we'll send you a benefit payment to use however you'd like.

- **Employees receive an annual benefit of $50**
- **Spouses receive an annual benefit of $50**
- **Children receive 50% of you benefit amount per child, with an annual maximum of $100 for all children**



RECEIVE $50

TO USE HOWEVER YOU LIKE!

Hospital Indemnity

A Hospital Indemnity plan is a voluntary plan that pays a cash benefit directly to you if you or a covered dependent is admitted into the hospital under the advice of a physician and you receive a bill for room and board. Benefit amounts paid to you depend on the type of facility and the number of days you are confined to a hospital.

HOSPITAL INDEMNITY INSURANCE BENEFITS APPLY IF YOU HAVE EMPLOYEE OR SPOUSE COVERAGE AND ARE HOSPITALIZED FOR CHILDBIRTH. IN ADDITION, YOUR NEWBORN CHILD(REN) MAY BE COVERED AS WELL.

- When existing child coverage is effective prior to birth, benefits for newborns are the same as for any other child.
- When child coverage is not effective prior to birth, a one-time benefit of $100 is payable for the newborn child's confinement due to birth. No admission benefit is payable.

PLANS OFFERED:

- Core
- Buy-up

HOSPITAL INDEMNITY COVERAGE OVERVIEW	
Is there a limit to how many times this benefit can be paid within a calendar year?	Yes, up to 8 times per covered person

COVERED BENEFITS		
Hospital	**Core**	**Buy-Up**
Admission - Paid on first day of hospital confinement.	$600	$1,200
Confinement - Daily benefit paid for up to 31 days per confinement and begins on day 2.	$100	$200
Critical Care Unit	**Core**	**Buy-Up**
Admission - Paid on first day of hospital confinement.	$700	$1,400
Confinement - Daily benefit paid for up to 31 days per confinement and begins on day 2.	$200	$400
Rehabilitation Facility	**Core**	**Buy-Up**
Confinement - Daily benefit paid for up to 31 days per confinement and begins on day 2.	$50	$100
Observation Unit Daily Benefit - Benefit payable up to 1 day per calendar year, for admission to a hospital observation unit for at least 4 consecutive hours other than as an inpatient.	$100	$100

A hospital is an institution that is run for the care and treatment of sick or injured persons.

A hospital is not institution or part of institution used as a hospice unit, a convalescent home, a nursing facility, free-standing surgical center, a rehabilitative facility, skilled nursing facility, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Pet Insurance

UVM Health Network has teamed up with Nationwide Insurance to offer employees coverage for their dogs, cats, birds, and exotic pets. My Pet Protection from Nationwide helps you provide your pets with the best care possible by reimbursing you for vet bills. You can get cash back for accidents, illnesses, hereditary conditions and more.

Pet parents have two levels of reimbursement (70% and 50%). Plan prices for UVMHN employees include a 5% discount; if you have multiple pets, you may qualify for discounts of up to 15%.* The cost of the plan is not based on pet age or breed, but rather reimbursement level and the state in which you reside.

All employees are eligible to enroll their pets. Upon enrollment you will set up a direct payment with Nationwide. Premiums for this plan will not be deducted from your paycheck. Coverage is effective 14 days following enrollment. Once your coverage is effective, you can visit any vet and then submit receipts for those services to Nationwide for reimbursement.

*UNFORTUNATELY, PRE-EXISTING CONDITIONS ARE NOT COVERED AND REIMBURSEMENT OPTIONS MAY NOT BE AVAILABLE IN ALL STATES.

ENROLLMENT

GET A QUOTE AND ENROLL IN ONE OF THE FOLLOWING WAYS:

- **Online at benefits.petinsurance.com/uvmhealth**
- **Calling (877) 738-7874, make sure to mention you are an employee of The University of Vermont Health Network to receive discounted pricing.**
  - If you are looking to enroll your bird, rabbit, reptile, or other exotic pet you must call to enroll in coverage.

NATIONWIDE PET INSURANCE			
Plan	**Deductible Per Pet**	**Reimbursement Options**	**Annual Maximum**
MY PET PROTECTION	**$250**	**70% Or 50%**	**$7,500**
Covers: Accidents, injuries, common illnesses, serious/chronic illnesses, hereditary/congenital conditions, surgeries/hospitalization, x-rays, MRIs, CT scans, prescription medications, and therapeutic diets			

BENEFIT PROVIDED BY:
Nationwide

CONTACT INFORMATION:

Enrollments
(877) 738-7874

Customer Care
(800) 540-2016

GROUP NAME:
The University of Vermont Health Network

WEBSITE:
petsnationwide.com

PLANS OFFERED:

- My Pet Protection

REIMBURSEMENT LEVELS:

- 70%
- 50%

ENROLLMENT & PREMIUMS:

You can enroll and make changes to your plan(s) at any time.

Premiums are paid monthly, by you, via personal auto-payment.

OTHER HELPFUL INFORMATION

- Enrollment Site
- Pet Insurance Overview
- FAQ's – Pre-enrollment
- FAQ's - Post-Enrollment
- FAQ's – Claim Reimbursement
- FAQ's - Vitus Mobile App
- Vethelpline®

Allstate Identity Protection

Every online transaction leaves a trace, taking on a life of its own, which can put your credit and identity at risk. Allstate Identity Protection is everywhere you can't be — monitoring your credit and helping you better protect your identity.

Identity Theft Protection is available for all benefit eligible employees as a voluntary benefit. Upon electing this benefit, Allstate Identity Protection offers you protection against identity theft.

FEATURES OF THE PLAN INCLUDE:

- **Identity and Credit Monitoring.** Enjoy peace of mind with proactive monitoring for the most damaging types of fraud. Your credit is monitored through TransUnion, Equifax, and Experian. Access a monthly credit score and a credit report each year from TransUnion.
- **Financial Activity Monitoring.** Stay ahead of fraud with alerts that are triggered from additional data sources on credit, debit and checking accounts.
- **Social Media Reputation Monitoring.** Actionable alerts help defend you and your family from reputational damage or cyberbullying. Privacy Armor monitors Facebook, LinkedIn, Twitter, and Instagram profiles.
- **Privacy Advocate® Remediation.** Experts help guide you through the identity restoration process and fight back against identity thieves.
- **$1,000,000 Identity Theft Insurance Policy.** If you are a victim of fraud, Allstate Identity Protection will reimburse your out of pocket costs to reinforce your financial security.

GETTING STARTED

You can purchase coverage for yourself or for yourself and your family.

Once you're enrolled, Allstate Identity Protection will email you information about accessing their online portal. You can use the Allstate Identity Protection portal to customize ongoing communication emails and text messages to fit your needs.

COVERAGE CONTINUATION

Coverage can be continued if your UVMHN employment ends. You have 90 days from your last day of employment to contact Allstate Identity Protection to arrange coverage.

BENEFIT PROVIDED BY:
Allstate Identity Protection

CONTACT INFORMATION:

Phone
(800) 789-2720

Email
clientservices@PrivacyArmor.com

GROUP NAME:
806

WEBSITE:
myaip.com/uvmhealthnetwork

PLAN OFFERED:

- Identity Protection Pro

COVERAGE LEVELS:

- Employee
- Employee & Family

PREMIUMS:

- Paid for by you
- After-tax from your paycheck

OTHER HELPFUL INFORMATION:

- Identity Protection Overview

Combined Time Off
(CTO)

Home Health & Hospice recognizes the varying time off needs of staff. Staff identified as regular full-time or regular part-time will be eligible to receive CTO.

The below chart outlines the accrual rate for a fulltime employee. Employees who work less than 40 hours per week will receive a prorated annual accrual.

Staff will be allowed to accrue up to one and a half times their annual CTO accrual.

FOR STAFF BENEFITED ON OR BEFORE JUNE 30, 2005		
Years of Service	**Annual Accrual**	**Maximum Accrual**
0-4 years	32	1.5x
5-9 years	37	1.5x
10-14 years	39	1.5x
14-19 years	40	1.5x
20+ years and CEO/VPs	42	1.5x
FOR STAFF BENEFITED ON OR AFTER JULY 1, 2005		
Years of Service	**Annual Accrual**	**Maximum Accrual**
0-4 years	28	1.5x
5-9 years	33	1.5x
10-14 years	35	1.5x
14-19 years	36	1.5x
20+ years and CEO/VPs	38	1.5x

Extended Sick Time

If you were employed on June 30, 1995 and had sick time remaining, Home Health and Hospice had an Extended Sick Bank established for you. The time available on June 30, 1995 was placed in the bank to be used as stated in the CTO policy. To be eligible to use the Extended Sick Time Bank, you must have missed three consecutive days and used CTO for those days.

Extended Sick time can also be used for a family member's illness on the fourth day of lost time. Family members in this policy refer to spouse, civil union partner, spousal equivalent, children, parents and parent-in-law, or any dependent living in the staff member's household. This policy is supplemental and will be administered so as not to conflict with the organization's Family Leave policy.

THE FOLLOWING HOLIDAYS* ARE RECOGNIZED:

- New Year's Eve
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving
- Christmas Day

* Employees who begin their shifts on or after 3 p.m. on Christmas Eve or New Year's Eve will be eligible for holiday shift differential for hours worked through the end of their shift if they are not working on the actual holiday. Day shift staff who works past 3 p.m. on either Christmas Eve day or New Year's Eve day will not be eligible for holiday pay for those hours that extend beyond 3 p.m.

- **You are expected to use CTO to cover hours not worked during holidays. If a holiday falls on a weekend, the organization will schedule the administrative holiday on either the Friday prior or the Monday following the holiday.**
- **Please see UVMHN Home Health & Hospice Employee Handbook for more information.**

CTO Cash-in

While Home Health & Hospice encourages you to take time off to ensure work-life balance, there is an opportunity two times during each fiscal year to cash-in CTO. During pay periods in the months of May and November, you may elect to voluntarily "cash-in" some of your Combined Time Off (CTO). Employees are limited to cashing in no more than two weeks (10 days) annually.

YOU MAY ELECT TO HAVE YOUR CTO DIRECTED TO:

- **your 403(b) account**
- **put into your paycheck**
  - If you have your CTO transferred to your paycheck, you should be aware the value will be taxed at the supplemental rate, which is approximately 39.4%.
  - All employees who wish to cash-in CTO must obtain supervisor approval on the CTO Cash-In Request Form prior to cashing in CTO time. This form is available in the Human Resources Office.

PLEASE NOTE: One day of CTO equals the number of hours regularly scheduled to work divided by 5 days. Example: 30 hours per week/5 days a week is 6 hours per day. A fiscal year runs from October 1 to September 30.

Voluntary Benefit Time Donation

Home Health & Hospice recognizes extenuating circumstance occur if an employee has a medical or family crisis that requires an extended absence. In such situations, other staff members may voluntarily donate portions of their CTO time bank to the staff member's extended sick bank (refer to the Medical and Emergency Leaves for guidelines).

- **Donations will be based on the dollar value of the donor's gifted hours**
- **Only CTO time can be contributed**
- **The employee donating benefit time will voluntarily initiate the donation procedure**
- **To transfer donated CTO time, a signed form must be submitted to Human Resources**
- **This procedure can be used only after all of the recipient's own benefit time has been depleted**
- **A list of donors will be made available to the recipient without notation of amount or value. Any donor wishing to remain anonymous may do so.**

Incentive Combined Time Off

(I-CTO)

All per diem staff who work a quarterly average of 22.5 hours a week or more will accrue I-CTO. This time can be used for vacation, sick, or personal days.

I-CTO is calculated based on actual number of hours worked as follows:

FOR STAFF BENEFITED ON OR BEFORE JUNE 30, 2005	
Hours Worked Per Quarter	**Hours of Incentive CTO**
0-22.5	0
22.5-30	11.25
30-37.5	15
37.5+	18.75

I-CTO is calculated quarterly and is deposited into the employee's "bank" in the first pay period of October, January, April, and July.

QUALIFICATIONS TO USE TIME:

- **You must request to use I-CTO at least 2 weeks in advance of the time, whenever possible.**
- **You must make the request directly to their supervisor for approval. If the supervisor cannot be reached, a request may be left with the scheduler or designee.**
- **You must indicate on your timesheet the use of I-CTO time.**
  - If you take an entire week, submit a timesheet and indicate in the "time-in" and "time-out" sections those hours that were taken as I-CTO time.

Leaves of Absence

Requesting a Leave of Absence can be stressful. It is important to have open communication with your manager prior to a leave of absence.

4 things you should do prior to a Leave of Absence:

- **Understand what benefits are available to you**
- **Notify your manager of your need for leave with as much advance notice as possible**
- **Call The Hartford to initiate a Leave**
- **Complete the CTO Use while on Leave form**

BENEFIT PROVIDED BY:
The Hartford

CONTACT INFORMATION:
(888) 716-4549

GROUP NUMBER:
697296

WEBSITE:
TheHartfordatWork.com

FOR LEAVE OF ABSENCE QUESTIONS, CONTACT THE HR SERVICE CENTER:

Phone
(844) 777-0886

Email
LOA@UVMHealth.org

FAMILY MEDICAL LEAVE ACT

(FMLA)

Family Medical Leave (FML) is an **unpaid** leave designed to provide job and benefit protection for employees while they are out of work for their own serious health condition or to care for a qualifying family member. For a full list of the reasons, including Qualifying Exigency Leave, that qualify for FML leave please visit the FMLA Policy located on the intranet or the FMLA Guidebook.

ELIGIBILITY FOR FML:

- Worked at Home Health & Hospice or an UVMHN affiliate for at least 12 months at the start of the leave
- Worked 1,250 during the 12-month period immediately before the start date of leave

ENTITLEMENT:

- Granted up to 12 weeks of time in a 12 month period
- Time can be used as continuous or intermittent, depending on need

WORKERS' COMPENSATION

Our employees are our most valuable resource. Home Health & Hospice recognizes a responsibility to assure the safest possible work environment for staff.

A commitment by staff to promote safe work practices is essential to this philosophy. There may be occasions when a work related injury or illness will occur. It is Home Health & Hospice policy to provide workers' compensation coverage for staff in such situations. Worker's compensation coverage provides for medical and wage reimbursement when a documented work related injury or illness occurs. When an injury occurs on the job, the employee must immediately report it to their supervisor. The employee or their supervisor must immediately report it to Human Resources. Failure to report a workplace injury in a timely manner may jeopardize an employee's ability to collect workers' compensation benefits.

BONDING LEAVE

Bonding Leave at Home Health & Hospice is provided under the Federal Family and Medical Leave Act (FMLA). Family Medical Leave (FML) is an unpaid leave designed to provide job and benefit protection for employees while they are out of work due to the birth of a son or daughter or placement of a son or daughter with the employee for adoption or foster care, and to care for the newborn or newly placed child (leave for these purposes must conclude within 12 months of the birth or placement.

VERMONT PARENTAL AND FAMILY LEAVE

In most cases Vermont Parental and Family Leave runs concurrently with Family Medical Leave and covers employees who work an average of 30 hours per week over the course of a year. Eligible employees may be granted up to twelve (12) weeks of Vermont Parental and Family Leave in a 12 month period. The leave is available for: pregnancy and/or after childbirth; within a year following the initial placement of a child 16 years of age or younger with the employee for purpose of adoption; or serious illness of the employee, employee's child, stepchild, ward, foster child, parent, spouse, or patent of the employee's spouse.

ACCOMMODATION UNDER THE AMERICAN WITH DISABILITIES ACT AMENDMENTS ACT (ADAAA)

Home Health & Hospice provides reasonable accommodation to the known physical or mental limitation of an otherwise qualified employee or applicant that would allow them to perform the essential functions of the role, unless such accommodation would cause an undue hardship to the organization.

Requests for reasonable accommodation may apply to needs within the employee's work environment or it may mean a temporary leave itself as an accommodation when the employee does not have other job-protecting leaves in place.

> • Requests for Accommodation under the Americans with Disabilities Act

VERMONT SHORT-TERM FAMILY LEAVE

Entitles the employee short-term family leave of up to 4 hours in any 30 day period, but not more than 24 hours in any 12 month period, of unpaid leave. The leave is available to participate in preschool or school activities directly related to the academic advancement of the employee's child, stepchild, foster child or ward who lives with the employee; to attend or accompany the employee's child, stepchild, foster child or ward who lives with the employee or the employee's parent, spouse or parent-in-law to routine medical or dental appointments; to accompany the employee's parent, spouse, or parent-in-law to other appointments for professional services related to their care and well-being; to respond to a medical emergency involving the employee's child, stepchild, foster child or ward who lives with the worker or the employee's parent, spouse, or parent-in-law.

You may use accrued paid leave, including CTO. When utilizing this leave, you must take time in increments of two hours or more.

MILITARY LEAVE

Employees ordered to military duty with the Armed Forces or with the reserve component will be granted an unpaid leave of absence for the period of service time as required by law. As the notice and re-employment provisions of that law are quite detailed and variable depending on the length of the military leave, employees should contact the Human Resources Department for details as soon as they have notice or knowledge of a potential military leave. Home Health & Hospice will comply with all applicable laws related to Military Leave.

OTHER LEAVES OF ABSENCE - SHORT TERM

- **Bereavement Leave**
  offered to provide continued pay during time off from work as a result of a death in the family. Employees may be granted up to three paid scheduled workdays following a death in their family. Supervisors may approve bereavement time for family or other losses when appropriate. Any paid time off above three days requires the approval of the Supervisor in consultation with the Program Director.
- **Extramural Activity Leave**
  provides up to 2 weeks of leave per year to allow an employee to contribute their skills and knowledge in their profession, which could include teaching, lead institutes, and make studies that support the mission of the organization.
- **Jury Duty**
  time will be excused from work with pay for the time required performing jury duty.
- **General Absence Without Pay**
  an employee may request unpaid time off not to exceed two weeks. Requests are to be made to the employee's direct supervisor, in writing, as far in advance as possible.

OTHER LEAVES OF ABSENCE – LONG-TERM

Benefit eligible employees who have at least six months of consecutive service are eligible for leave with or without the use of accrued benefit time.

QUALIFICATIONS AND REQUIREMENTS NOTED ARE:

- No guarantee of position upon the expiration of a leave, employees are encouraged to discuss this with their supervisor prior to submitting their request, when possible.
- Group health insurance premiums usually paid by the designation of the employee's flexible benefits will continue.
- If an employee wants to maintain health insurance coverage during the leave, they will make arrangements with Human Resources prior to the leave. A failure to reimburse or follow through on a payment plan for employee owed portions will result in forfeiture of coverage. Prepayment is accepted.
- When returning, 10 day notice is required.
- If the employee does not return, these premiums will be owed to the organization. All other designated benefit package money accrued during the leave will be available upon return to actual status (provided that return is within the three-month guideline). Failure to otherwise report for work upon expiration of a leave will result in termination.
- A leave of 12 weeks or less will not affect the employee's anniversary date.
- A new benefit accrual date is established by adding the total leave time taken to the effective anniversary date. This change in the anniversary date affects seniority at the termination date will be the last day worked.
- Whether or not the position vacated will be temporarily filled will be determined by the Program Director.

- **Emergency Leave**
  up to six months unpaid leave in the event they are unable to work due to personal crisis that requires time off.
- **Educational Leave of Absence**
  unpaid leave of absence for up to 12 months may be granted to an employee who has completed one (1) year of service to pursue educational opportunities that promote an employee's growth and development at Home Health & Hospice.

- **General Leave**
  In unusual circumstances, a request for unpaid general leave may be considered.
  The following guidelines will be used:
  - Employee must have at least two years' service
  - Request must be made in writing four weeks prior to leave
  - If approved, understanding will be made that their position will likely be filled
  - Maximum length of Leave is six months, with possible extension of another 6 months
  - The employee will be considered for the first available position of a similar level and pay rate for which they are eligible and qualified, if returning within 12 months

Employee Assistance Program

As an employee, you and your eligible dependents automatically have access to an Employee Assistance Program (EAP). No enrollment is necessary. This program is provided as part of the organization's commitment to promoting employee health and wellbeing. It is offered at no charge to the employee and provides a valuable resource for support and information during difficult times, as well as consultation on day-to-day concerns. EAP is an assessment, short-term counseling and referral service designed to provide you and your family with assistance in managing everyday concerns. EAP offers confidential clinical help for everyday people with everyday problems.

Specially trained customer service representatives and professional EAP counselors are available 24 hours a day, 7 days a week to confidentially discuss your concerns and ensure that you receive the assistance you need.

EAP CONFIDENTIALITY

Confidentiality is the hallmark of the program and is essential to the success of the program and is no different than using any of your other benefits such as medical, dental or vision. Nobody besides the person accessing EAP knows that they've gone or why, unless they tell someone.

This is one of the most important things to know about this program, besides the fact that all services are free; the program is strictly confidential and that your privacy is protected by law. With only a few obvious exceptions your confidentiality is protected. Nobody from work, nobody from your family can find out if you've used any part of the EAP program. No reports are made except aggregate utilization reports that do not identify individuals.

EAP FOR HELP WITH

- Marriage and family problems
- Job-related issues
- Stress, anxiety and depression
- Parent and child relationships
- Legal and financial counseling
- Identity theft counseling
- Financial planning
- Various other issues

EAP TYPES OF SERVICES

Clinical - Emotional Health (face-to-face and telephonic) is still the biggest part of what we do. Think of this as confidential clinical help for everyday people with everyday problems.

Work and Life - (face-to-face and telephonic) are types of benefits and resources that include things like free legal and financial consultations, identity protection and recovery, child and elder care, and much more.

Online Resources and Information - includes self-help assessments and online libraries filled with information.

IF YOU NEED HELP, CONTACT TOLL-FREE, 24 HOURS A DAY, SEVEN DAYS A WEEK, CALL:

- (866) 660-9533
- or visit, INVESTEAP.ORG
  PASSWORD: HomeHealth

Tuition and Continuing Education

Tuition and Continuing Education Reimbursement is designed to help you with financial support to grow personally and professionally.

Reimbursement is provided for undergraduate and graduate coursework as well as external continuing education opportunities.

Funds are available through the Continuing Education Reimbursement Fund and the budget.

TUITION REIMBURSEMENT

- **Eligible after one year of employment.**
- **Course must be from an accredited post-secondary institution or an approved specialty certification.**
- **Must be job related and/or coursework as part of a degree program.**
- **75% of the cost will be reimbursed up to $1,000 per course.**
- **Maximum benefit annually is $2,000.**
- **Must receive a passing grade of "C" for undergraduate, "B" for graduate, or Pass for reimbursement.**

CONTINUING EDUCATION

- **Eligible after six months of employment.**
- **Workshops, seminars, and conferences may be reimbursed.**
- **100% reimbursement up to a maximum of $750 annually.**

Tuition Reimbursement and Continuing Education benefits are pro-rated for employees working less than full-time.

Affordable Care Act

In 2010, the federal government enacted the Affordable Care Act, a comprehensive health care reform law that phased in a series of actions over an eight-year period.

THE ACA IS INTENDED TO:

- **Provide all Americans access to health care**
- **Lower the cost of quality health care**
- **Protect consumers' health care rights**

To expand health care coverage, as part of the Employer Shared Responsibility Provision of ACA, also known as the employer mandate, all employers with 50 or more full-time equivalent employees (FTE) are required to provide minimum essential medical coverage (MEC) to at least 95 percent of their full-time employees and dependents up to age 26.

FULL-TIME EMPLOYEES FOR ACA PURPOSES ARE THOSE WHO WORK, OR ARE EXPECTED AT HIRE TO WORK, AN AVERAGE OF 30 HOURS OR MORE PER WEEK.

Employers are also required to report coverage information to the IRS and furnish covered individuals with a form that shows compliance with the individual shared responsibility provision of ACA. The annual notification, also known as the IRS Form 1095-C, must be sent annually to full-time employees and individuals covered by a self-insured plan by the end of January.

UVM HEALTH NETWORK'S ACTION UNDER ACA

The ACA employer mandate covers all UVMHN employees who work full time by ACA standards. Full-time employees for ACA purposes are those who work, or are expected at hire to work, an average of 30 hours or more per week. They include not only UVMHN's benefits-eligible employees, but also UVMHN's part-time, regularly scheduled special, and per diem employees. Employees who meet the ACA's full-time standard are referred to at UVMHN as "ACA-eligible" employees.

THERE ARE THREE METHODS FOR DETERMINING ELIGIBILITY UNDER THE ACA:

- **Method 1 – Hire:**
  Employee is hired into a position that is expected to average 30 or more hours per week based on the weekly authorized hours entered into Workday, the employee is determined to be ACA-Eligible for coverage.
- **Method 2 – Hire with Look Back:**
  Employee is hired into a position that is expected to average 30 or more hours per week based on the weekly authorized hours entered into Workday, the employee is determined to be ACA-Eligible for coverage.
  - If an employee is eligible for insurance and reduces their hours at some point in the year, they are able to maintain their coverage for the remainder of the year assuming they continue employment and had an average of 30 hours per week prior to the reduction.
- **Method 3 – Annual Look Back:**
  An annual "look back" is performed for employees who are not eligible for the standard medical insurance plans, by looking at their worked hours for UVMHN over the past year (from November through October). The annual "look back" is to determine if the employee averaged 30 or more hours per week based on the actual time worked. If the hours average 30 or more per week, the employee is ACA-Eligible for coverage beginning January 1 of the following year.

2020	2021						2022					
Nov	Jan	Mar	May	Jul	Sep	Nov	Jan	Mar	May	Jul	Sep	Nov
Measurement Period • Total number of hours worked: **1,596** • Average number of hours worked per month: **133**						**Wait Period**	**Stability Period** • Employee is determined to be full-time • Employee must be offered benefits					

ACA-ELIGIBLE EMPLOYEE MEDICAL COVERAGE AT UVMHN

To comply with the ACA employer mandate, all ACA-eligible employees are offered the UVMHN HDHP 3000. The ACA Plan is a high deductible health plan that provides affordable minimum essential medical coverage (MEC) of minimum value (MV) to ACA eligible employees and their eligible dependent children up to age 26.

Please note: The ACA requires employers to offer minimum essential coverage (MEC) to ACA-eligible employees and their eligible dependent children up to age 26. Therefore, the ACA Plan does not provide spousal coverage.

ACA-ELIGIBLE OPEN ENROLLMENT

Those who qualify for ACA-Eligible medical coverage will be notified about the opportunity to elect UVMHN medical coverage. An annual Open Enrollment will be held in the fall for coverage beginning January 1 of the following year. During this time, employees may elect the ACA Plan for medical coverage.

Please note: As part of the ACA's individual shared responsibility, all individuals must have qualifying health insurance coverage for the year, either through employer coverage or through the Health Insurance Marketplace, such as Vermont Health Connect, the private health exchange for Vermont residents. Before enrolling in the UVMHN ACA Plan, employees may want to compare the ACA Plan coverage and costs with the medical plan options offered through Vermont Health Connect.

HOW TO ENROLL

Employees determined to be ACA-Eligible employees will receive notification of their ACA-Eligible opportunity either at hire, at first anniversary or at the annual Open Enrollment period. When the enrollment period begins, ACA Plan elections can be made online through Workday until the end of December.

PAYING FOR COVERAGE

You are responsible for paying premiums each pay period. Premiums will be removed from your paycheck on a pre-tax basis if you work during the pay period. If you do not work during the pay period, you will be billed for payment via personal check or credit card. All payments are due within 30 days. Failure to pay could result in cancellation in coverage.

ACA INDIVIDUAL REPORTING OF THE OFFER OF COVERAGE – 1095(C)

The Affordable Care Act (ACA) requires that certain employers provide you with an IRS tax form called Form 1095-C Employer-Provided Health Insurance Offer and Coverage.

UVMHN will send eligible employees the IRS Form 1095-C each January, whether they elect UVMHN coverage or not. This form details the coverage made available by UVMHN in the prior year.

ACTION AFTER RECEIVING IRS FORM 1095(C)

You will need the information from your IRS Form 1095-C when you complete your Federal income tax return. Keep the form as your "proof of coverage" for the ACA individual mandate. At this time, you are not required to submit it to the IRS with your tax return.

The 1095-C form provides documentation of employer-provided health coverage offered to you, as well as enrollment information for you and your dependents as required under the employer shared responsibility provision of the Affordable Care Act (ACA).

You may receive more than one of these Forms if you changed employers or medical plans mid-year.

ANNUAL TIMELINE FOR ACA ACTIONS

TIMELINE	ACA ACTION	ACTION
November	**Measurement**	Look Back Reporting: All employees are "measured" for ACA Full-time status based on worked hours in the prior 12 months.
November	**Notification**	Notifications sent to ACA Full-time eligible employees with enrollment details. Any ACA enrolled employees in the current year who will not qualify in the next calendar year will be notified regarding their coverage end date.
November - December	**Enrollment**	ACA - Eligible Open Enrollment Period. Medical elections are made within Workday for coverage for themselves and any dependent child(ren).
January	**Coverage Begins**	Elected ACA medical coverage begins on January 1.
February	**ACA - Reporting**	Form 1095-C will be provided at the end of January. Employees may elect to receive Form 1095 electronically (e-delivery), by logging into Workday and electing the delivery preference. If electronic distribution is not selected, it will be sent via U.S. Mail.

COBRA Overview

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides eligible covered employees and their dependents the opportunity to temporarily extend their health coverage when coverage has been terminated.

The election to continue coverage must be made within a specified election period. If elected, coverage will be reinstated retroactive to the date following termination of coverage. There is no lapse in coverage.

An initial notice is provided to all new employees upon enrollment in any health plans at UVMHN. This notice is to explain the COBRA law, our notification obligations and your potential rights to COBRA coverage if loss of group health coverage should occur.

LOSING COVERAGE UNDER UVMHN PLANS

When you or a covered dependent lose eligibility to participate in UVMHN's health plans, the coverage will be terminated. However, under most circumstances, you may continue the medical/prescription, dental, vision and health care flexible spending account benefits coverage through COBRA.

COBRA coverage is generally offered for up to 18 months, or longer depending on the circumstances. When you begin participation in COBRA, you may only continue the benefits in which you were enrolled at the time your coverage was lost. However, you may change the level of coverage (e.g., family to employee and child). Covered dependents retain COBRA eligibility rights even if the employee chooses not to enroll.

ENROLLING IN COBRA BENEFITS

When you separate from UVMHN or lose coverage, EBPA, our COBRA administrator will send you a COBRA qualifying event notice. You will then have 60 days from the date of cancellation of your coverage or the date of the notification, whichever is later, to elect to continue your benefits through COBRA. You will remit your payments directly to EBPA. Your COBRA coverage will be retroactive to the date your coverage would have terminated.

Timely submission of COBRA elections and payments are important – you will not be allowed to elect COBRA if you miss the election deadline. Your benefits will be automatically canceled unless the required premiums are paid on or before the due date. Once COBRA benefits are canceled because of nonpayment, they will not be reinstated. You and/or your covered dependents are responsible for notifying the COBRA Administrator of a divorce, legal separation or a child losing dependent status while covered under the Plan so COBRA enrollment can be initiated.

The life insurance coverage in force on the date of termination is not available through COBRA; however, the employee and/or dependent may be eligible to convert or port their life insurance coverage. See the Life Insurance Coverage Certificate for details.

BENEFIT PROVIDED BY:
EBPA

CONTACT INFORMATION:
(888) 232-3203

PLANS AVAILABLE FOR CONTINUATION:

- Medical
- Dental
- Vision
- Health Care Flexible Spending Account

PREMIUMS:

The full cost plus 2% administration fee is paid for by you.

Premiums are paid directly to the COBRA Administrator.

PAYING FOR COBRA THROUGH EBPA

If you continue coverage under COBRA you'll pay the full premium cost (including both employee and employer costs) plus a 2% administrative fee, for a total cost of 102%.

The amount due each month for each qualified beneficiary will be included in the COBRA election notice provided to you at the time of your qualifying event. The cost of COBRA coverage may change from time to time during your period of COBRA eligibility and those premiums may increase over time.

QUALIFYING EVENT	QUALIFIED BENEFICIARIES	MAXIMUM COBRA PERIOD
Termination of Your Employment	You & Your covered dependents	18 months after loss of coverage
Reduction in Hours of Employment - making you ineligible for benefits		
Dependent Child who obtains age 26	Impacted Dependent	36 months after loss of coverage
Divorce or legal separation	Your ex-spouse & other affected dependents	
Your Death	Your covered dependents	
Your Failure to return to employment following a Family Medical Leave (FMLA)	You & Your covered dependents	18 months after loss of coverage
You become enrolled in Medicare coverage less than 18 months before your initial qualifying event (termination of employment or reduction in hours) and you lose coverage under the plan due to the initial qualifying event	Your covered dependents	36 months after your enrollment in Medicare
You or an eligible dependent becomes disabled during the first 60 days of COBRA continuation coverage and disability continues at least until the end of the original continuation period	You, your covered dependents and any child born to you, adopted by you or placed for adoption with you during your period of COBRA coverage	Coverage can be extended from the original 18-month period to 29 months, provided you notify the COBRA administrator within 65 days.

Your group numbers and monthly rates will change, but the plan details remain the same. You cannot make other changes until the next open enrollment period, unless you experience a life or family status change.

If enrolled in an HDHP through Cobra, you will not receive any employer funding to your health savings account.

Important Legal Notices for Home Health & Hospice

NOTICE OF SPECIAL ENROLLMENT RIGHTS

A federal law called HIPAA requires that we notify you about a very important provision in the Plan. Specifically, your right to enroll in the Plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this Plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect (including COBRA coverage), you may be able to enroll yourself and your dependents in this Plan. If you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage or COBRA ends (or after the employer stops contributing toward the other coverage). If you have COBRA, you must exhaust that coverage to be eligible to enroll in the Plan mid-year.

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan, you may be able to enroll yourself and your dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the Plan's special enrollment provisions, contact Benefits at (844) 777-0886 or HRSolutionCenter@UVMHealth.org.

NOTICE OF PATIENT PROTECTIONS

The UVMHN Medical Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Cross Blue Shield (BCBS) designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCBS at (833) 578-1126.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from The University of Vermont Health Network Medical Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact BCBS at (833) 578-1126.

LIFETIME AND ANNUAL LIMITS

All Health Insurance Plans offered at UVMHN do not impose a lifetime limit on essential health benefits. This is in order to comply with the Affordable Care Act (ACA). Questions regarding protections can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered and non-grandfathered health plans.

PREVENTIVE COVERAGE UPDATES

The Affordable Care Act – the health insurance reform legislation passed by Congress and signed into law by President Obama on March 23, 2010 – helps make prevention affordable and accessible by requiring health plans to cover preventive services and by eliminating cost sharing for those services. Preventive services that have strong scientific evidence of their health benefits must be covered and plans can no longer charge a patient a co-payment, coinsurance or deductible for these services when they are delivered by a network provider. The list of covered preventive services is updated annually as changes in recommendations occur. In the last several years, the list was updated to include special preventive services for women, such as contraceptive coverage, genetic testing for breast cancer, chemo-preventive drugs for breast cancer such as Tamoxifen and Raloxifene (where medically indicated), and BRCA risk assessment and genetic counseling/testing for women with certain cancer risks. Smoking cessation counseling and prescriptions are another example of expanded services. For more information about covered preventive services, visit BCBS's website.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits under the Plan, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- **all stages of reconstruction of the breast on which the mastectomy was performed;**
- **surgery and reconstruction of the other breast to produce a symmetrical appearance;**
- **prostheses; and**
- **treatment of physical complications of the mastectomy, including lymphedema.**

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. The deductibles and coinsurance are found in the Plan's summary plan description. Contact BCBS for more information about your rights under WHCRA. If you have any questions about the coverage of mastectomies and reconstructive surgery under the Plan, please call Member Services at (833) 578-1126, or visit myheathtoolkitvt.com.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

COVID-19 RELATED SERVICES

The Families First Coronavirus Relief Act (FFCRA), as amended by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), requires health plans to cover without cost sharing, prior authorization, or medical management certain COVID-19-related diagnostic tests (including antibody tests), services, and products. The period during which the coverage mandate applies begins on March 18, 2020 and will end when the COVID-19 public health emergency is no longer in effect. The service covered at no cost include items and services that are provided during a diagnostic office, emergency room, or urgent care visit so long as the visit results in the administration of or order for the COVID-19 test, provided the products relate to the furnishing or administration of the test or evaluating the individual for the need of the testing.

Appendix

WHEN BENEFITS BEGIN AND END

BENEFIT TYPE	Who Pays		How To Enroll In Coverage	Benefit Start Date	Making Changes	
	HHH	You			Qualifying Event	Open Enrollment
403(B)	✓	✓	Fidelity at Work	Your contributions - immediately Home Health and Hospice contributions -annually, following Board approval	Anytime	
MEDICAL INCLUDING PRESCRIPTION COVERAGE	✓	✓	Workday	1st of month following date of hire or qualifying event date. If your date of hire or qualifying event date is the 1st of the month, your benefits will begin that day. Any benefit changes resulting from the birth of a child will begin on the date of the child's birth.	✓	✓
HOSPITAL INDEMNITY		✓			✓	✓
CRITICAL ILLNESS		✓			✓	✓
ACCIDENT		✓				
DENTAL	✓	✓			✓	✓
VISION		✓			✓	✓
FLEXIBLE SPENDING ACCOUNT		✓			✓	✓
HEALTH SAVINGS ACCOUNT	✓	✓			Anytime	
LIFE INSURANCE (1 TIMES ANNUAL SALARY)	✓		Automatically Enrolled		✓	✓
VOLUNTARY ADDITIONAL LIFE, SPOUSE LIFE, AND CHILD LIFE		✓	Workday Evidence of Insurability will be emailed after enrollment, if required.	1st of month following date of hire, qualifying event date, or upon approval from The Hartford, whatever is later.	✓	✓
SHORT-TERM DISABILITY	✓		Automatically Enrolled	Coverage begins after 1 year.	N/A	
LONG-TERM DISABILITY	✓			1st of month following date of hire or benefit eligibility date. If your date of hire or qualifying event date is the 1st of the month, your benefits will begin that day.		
COMBINED TIME OFF (CTO)	✓		Automatically Enrolled	Hire Date or Benefit Eligibility Date		
TUITION REIMBURSEMENT	✓		Concur	Start of course following 6 months or 1 year of service. Refer to Policy. More Info	N/A	
CONTINUING EDUCATION	✓			After 6 months of employment		
IDENTITY THEFT PROTECTION		✓	Workday	January 1 following enrollment		✓
PET INSURANCE		✓	Nationwide	14 days following enrollment	Anytime	

SPENDING AND HEALTH SAVINGS ACCOUNT OVERVIEW				
	General Purpose FSA	**Limited Purpose FSA**	**Health Savings Account**	**Dependent Care FSA**
Calendar Year Contribution Limits	From $150 to $2,850		Single: $3,650 Family: $7,300 $1,000 catch-up contribution for anyone 55 or older Limit includes any UVMHN contributions made to your account.	From $150 to $5,000 for individuals, married couples filing jointly. The limit is $2,500 for a married person filing separately.
When is the money available for me to use for expenses?	Immediately		UVMHN will make contributions to your account 4 times per year. You have access to the amount you have contributed through payroll deductions.	Contributions are added to your account after each payroll deduction. You have access to the amount you have contributed through payroll deductions.
Who makes contributions?	You		UVMHN and You	You
Do I have the ability to makes changes to my contribution mid-year?	No, unless you have a qualifying life event or at annual open enrollment.		Anytime.	No, unless you have a qualifying life event or at annual open enrollment.
Can I invest my contributions?	No		Yes, once your balance reaches $1,000.	No
What are the eligible expenses under these plans?	Medical, Prescription, Dental and Vision Expenses	Dental and Vision Expenses	Medical, Prescription, Dental and Vision expenses, and some insurance premiums such as COBRA and Medicare.	Child or Elder care while you are at work.
	Complete list available via IRS.gov, under Publication 502.			Complete list available via IRS.gov, under Publication 503.
When do I have to incur expenses?	January 2022 - December 2022		There is no deadline to incur or submit an expense. Just submit a claim whenever you would like to reimburse yourself. You own the account, so the money does not need to be used within any timeline.	January 2022 - March 15, 2023
If I have unused money at the end of calendar year, what happens?	You are allowed to carry over up to $570 of unused balance to the following plan year. Anything above $570 is forfeited.			If you have unused funds after March 15, 2022, they will be forfeited.
When do I have submit expenses by in order to not lose any money?	May 31, 2023			May 31, 2023
What happens if I switch employers or retire?	You have until the last day of employment to incur expenses. If you have unused money, you can choose to elect Cobra to extend your time to incur expenses, or you would forfeit those funds.			You have until the last day of employment to incur expenses. If you have unused money, you forfeit those funds.

2022 EMPLOYER HSA CONTRIBUTIONS

2022 EMPLOYER HSA CONTRIBUTIONS		UVMHN HDHP WITH HSA PLAN – 1500		UVMHN HDHP WITH HSA PLAN-3000	
Month Contribution will be made	**Hire Date/ Qualifying Date ***	**Single**	**Family**	**Single**	**Family**
January	January - March	$250	$500	$500	$1,000
April	April - June	$84	$167	$167	$334
July	July - September	$83	$166	$166	$333
October	October - December 1	$83	$166	$166	$333
* Contributions will be made within 30 days of hire or qualifying event date.					

ADDITIONAL LIFE INSURANCE RATES

Bi-weekly Rates are per $1,000 of Coverage	Employee	Spouse
	Term Life with AD&D	
Age 24 and Under	$0.0300	$0.0323
25-29	$0.0268	$0.0295
30-34	$0.0300	$0.0323
35-39	$0.0397	$0.0434
40-44	$0.0554	$0.0618
45-49	$0.0882	$0.0983
50-54	$0.1375	$0.1542
55-59	$0.2054	$0.2303
60-64	$0.2511	$0.2820
65-69	$0.3535	$0.3978
70-74	$0.6208	$0.6997
Age 75 and Over	$1.8180	$2.0502
Child Term Life with AD&D	$10,000 Benefit $0.272	

CALCULATING LIFE INSURANCE PREMIUMS:

You are electing $100,000 of additional coverage (which includes an additional $100,000 of AD&D coverage) and you are 47 years old

$100,000 / $1,000 = $100 x $0.0882 = $8.82

Bi-weekly premium for $100,000 of coverage will be $8.82 or $229.32 annually

You are electing $50,000 of spouse life insurance and they are 43 years old

$50,000 / $1,000 = $50 x $0.0618 = $3.09

Bi-weekly premium for $50,000 of coverage will be $3.09 or $80.34 annually

IMPUTED INCOME ON EMPLOYER PAID LIFE INSURANCE

CALCULATING IMPUTED INCOME ON EMPLOYER PAID LIFE INSURANCE ABOVE $50,000

To determine the amount of imputed income – use your age at the end of the calendar year and the rates noted to the right.

You have $64,000 in term coverage

Imputed Income only applies to $14,000 – the amount of coverage above $50,000

Your age at the end of the calendar year – 47 (Rate from Chart: $0.069)

$14,000 / $1,000 = $14 x $0.069 = $0.97

You would have $0.97 of additional taxable income each pay period or $25.22 annually. $41.60 annually.

BI-WEEKLY IMPUTED INCOME RATE PER $1,000 OF BENEFIT	
Age 24 and under	$0.023
Age 25 – 29	$0.028
Age 30 – 34	$0.037
Age 35 – 39	$0.042
Age 40 – 44	$0.046
Age 45 – 49	$0.069
Age 50 – 54	$0.106
Age 55 – 59	$0.198
Age 60 – 64	$0.305
Age 65 – 69	$0.586
Age 70 and over	$0.951

HOSPITAL INDEMNITY INSURANCE - VOYA

HOSPITAL INDEMNITY RATES	CORE PLAN		BUY-UP PLAN	
	Your Bi-weekly After-tax Rate	Your Annual Cost	Your Bi-weekly After-tax Rate	Your Annual Cost
Employee	$4.56	$118.68	$8.89	$231.12
Employee + Spouse	$9.94	$258.48	$19.51	$507.36
Employee + Child(ren)	$7.73	$200.88	$15.16	$394.20
Family	$13.10	$340.68	$25.79	$670.44

CRITICAL ILLNESS – VOYA

VOYA CRITICAL ILNESS- CORE PLAN				
EMPLOYEE: $10,000 SPOUSE: $10,000 CHILD(REN): $5,000				
Attained Age	**Employee**	**Employee + Spouse**	**Employee + Child**	**Family**
Under 25	$0.88	$2.45	$1.34	$2.91
25 - 29	$1.06	$2.81	$1.52	$3.27
30 - 34	$1.29	$3.23	$1.75	$3.69
35 - 39	$1.62	$3.93	$2.08	$4.39
40 - 44	$2.91	$6.69	$3.37	$7.15
45 - 49	$4.52	$9.87	$4.98	$10.33
50 - 54	$7.06	$15.74	$7.52	$16.20
55 - 59	$8.45	$20.36	$8.91	$20.82
60 - 64	$10.66	$23.58	$11.12	$24.04
65 - 69	$11.26	$25.20	$11.72	$25.66
70 +	$13.38	$28.06	$13.84	$28.52

VOYA CRITICAL ILNESS- BUY-UP PLAN				
EMPLOYEE: $20,000 SPOUSE: $20,000 CHILD(REN): $10,000				
Attained Age	**Employee**	**Employee + Spouse**	**Employee + Child**	**Family**
Under 25	$1.75	$4.89	$2.67	$5.81
25 - 29	$2.12	$5.63	$3.04	$6.55
30 - 34	$2.58	$6.46	$3.50	$7.38
35 - 39	$3.23	$7.85	$4.15	$8.77
40 - 44	$5.82	$13.39	$6.74	$14.31
45 - 49	$9.05	$19.76	$9.97	$20.68
50 - 54	$14.12	$31.47	$15.04	$32.39
55 - 59	$16.89	$40.71	$17.81	$41.63
60 - 64	$21.32	$47.17	$22.24	$48.09
65 - 69	$22.52	$50.40	$23.44	$51.32
70 +	$26.77	$56.12	$27.69	$57.04

ACCIDENT COVERAGE - VOYA

VOYA ACCIDENT RATES		
Core Plan	**Your Bi-weekly After-tax Cost**	**Your Annual Cost**
EE	$1.63	$42.48
EE + Spouse	$3.63	$94.32
EE + Children	$3.24	$84.12
Family	$5.23	$135.96

Buy-Up Plan	Your Bi-weekly After-tax Cost	Your Annual Cost
EE	$3.08	$80.16
EE + Spouse	$6.58	$171.12
EE + Children	$6.16	$160.08
Family	$9.66	$251.04

IDENTITY THEFT PROTECTION – ALLSTATE

ALLSTATE IDENTITY PROTECTION PRO PLAN	Your Bi-weekly After-tax Rate	Your Annual Cost
Employee	$3.67	$95.40
Family	$6.44	$167.40

Common Health Insurance Terminology

AGGREGATE/NON-EMBEDDED VS. EMBEDDED DEDUCTIBLE

An aggregate (non-embedded) deductible is when the entire family deductible for a family health care plan must be met to receive a reimbursement from BCBS. The deductible can be reached by one family member or a combination of members within the family. UVMHN plan will have an aggregate deductible on the 2 high deductible health plans (HDHP 1500 and HDHP 3000).

An embedded deductible is when individual members in a family health care plan only need to meet their own deductible before BCBS will begin to pay for services. UVMHN plan will have an embedded deductible on the 2 traditional health plans (Premier 250 and Premier 400).

ALLOWED AMOUNT

The most money that your BCBS Plan will pay toward a health care service.

BENEFIT YEAR

The year or period of time that your insurance coverage starts and stops. UVMHN's benefit year follows the calendar year.

CARVE-OUT

An employer group utilizes a different insurance company to administer a specific benefit instead of its primary health insurance provider.

UVMHN has a carve-out of its prescription drug coverage, by utilizing Navitus Pharmacy Solutions.

COINSURANCE

The percentage of the bill you pay for a covered product or service. Unlike a copay, which is a flat amount, coinsurance is a percentage of the cost of the service. If your health plan has a deductible, the coinsurance is the amount you're responsible for after your deductible is met.

COPAYMENT/CO-PAY

The amount you pay for a health care service, like a doctor visit. The amount depends on your plan, the provider, and the type of service you receive. In addition, prescription medications also require copays, and they will vary depending on the medication.

DEDUCTIBLE

The amount of money you pay for covered health care services before your health insurance starts to pick up the tab. If your cost exceeds the deductible, your plan will cover a percentage of the remainder (90% or 95%) and you would be responsible for the remaining cost (5% or 10%). This is called coinsurance.

ER, URGENT CARE, OR PCP?

While you may be familiar with the terms emergency room (ER), urgent care, and primary care physician (PCP), do you know which to visit for a health issue – and when?

Deciding the best course of action can be critical for getting the most effective care for your medical needs. A PCP knows your medical history and can treat you with your unique health needs in mind, while an urgent care facility can be very convenient when your doctor's office is closed. Of course, the ER is the best option when emergency care is needed.

Making the right choice can also save you money. While you should always go to the ER for serious health emergencies, visiting your PCP is a more cost-effective option under normal circumstances.

EXCLUDED SERVICES

Any health care service that BCBS does not pay for or will not cover. You can find a list of excluded services in your Summary Plan Description (SPD).

EXPLANATION OF BENEFITS (EOB)

At first glance, it may appear to look like a bill – it's not. An EOB is a statement that BCBS sends in the mail after you receive a health service. It tells you how much the provider charged, how much BCBS will allow, how much your insurance paid, and the amount you may owe.

An EOB is great documentation for submitting for reimbursement under a Flexible Spending Account (FSA) or Health Savings Account (HSA).

FORMULARY

A list of approved prescription drugs Navitus will pay for, based on the efficacy, safety, cost-effectiveness, and overall value of the drug. The formulary is set by Navitus' Pharmacy and Therapeutics Committee. This committee consists of independent, actively practicing physicians and pharmacists.

If your doctor prescribes you a new medication, it's always good to ask the physician if the drug is covered by your health insurance. The doctor will be able to tell if the drug is covered by looking up your plan's prescription drug formulary.

Under UVMHN's traditional health plans, the formulary is divided into three tiers, with varying co-pay amounts (Tier 1 has the lowest copay and Tier 3 has the highest). Under UVMHN's high deductible health plans, you will pay your deductible and then co-pays. Regardless of the plan you are enrolled in, utilizing UVMHN's Retail or Mail Order Pharmacies, you will save money on your prescriptions.

FSA

A flexible spending account (FSA) allows employees to set aside pre-tax dollars for specific, qualified health and/or dependent care expenses. The money is deducted directly from the employee's paycheck and is not subject to payroll taxes. You can only enroll in an FSA if enrolled in a traditional health insurance plan.

HSA

A health savings account (HSA) is owned by the individual (not by the employer) and can be used to pay for qualified medical expenses without federal tax penalty.

DOMESTIC NETWORK, IN-NETWORK VS. OUT-OF-NETWORK

The Domestic Network refers to any providers or facilities within The University of Vermont Health Network. All UVMHN providers and facilities are contracted with BCBS. Domestic services have the lowest cost-share.

In-network providers and facilities are providers BCBS has contracted with under your health coverage. In-network does not mean a provider or facility needs to be located in Vermont or New York. BCBS provides network coverage nationally.

Out-of-network refers to any providers or facilities that have not contracted with BCBS. When utilizing out-of-network care you will be responsible for a higher percentage of cost-share.

MEDICALLY NECESSARY

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms that meet accepted standards of care.

MEDICARE

Medicare is a federally governed health care program for people ages 65 or older. Certain people with disabilities and those with end-stage renal disease are also eligible for this program. There are four basic components:

MEDICARE PART A (HOSPITAL INSURANCE)

Covers inpatient services, including hospital stays, home health, hospice, and limited skilled nursing facility services.

MEDICARE PART B (MEDICAL INSURANCE)

Covers outpatient services, including physician services, medical supplies, and other outpatient treatment. After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

MEDICARE PART C (MEDICARE ADVANTAGE PLANS)

A managed Medicare Advantage plan. With this type of plan, qualified individuals and groups would have their Medicare coverage provided through an insurer, such as CDPHP. They must be eligible for Medicare Part A and Part B. Medicare Advantage plans can provide prescription drug coverage (Part D).

MEDICARE PART D (PRESCRIPTION DRUG COVERAGE)

A federal program to help cover the costs of prescription drugs for Medicare recipients in the United States.

NETWORK

The facilities, providers, and medical suppliers BCBS has contracted with to provide health care services. A network could range from a primary care physician (PCP), to a chiropractor, to a nursing home.

OUT-OF-POCKET MAX

Many people don't realize that every health insurance plan sets a maximum for the amount you will have to pay, referred to as the out-of-pocket maximum (OOP max). Once you have reached your OOP max, BCBS will begin to pay 100% of the costs for covered care. Different plans have different OOP maximums.

OUTPATIENT CARE/AMBULATORY CARE

Care in a hospital that doesn't require an overnight stay. Examples of hospital outpatient services include lab tests, physical therapy, minor surgeries, and X-rays. Outpatient services typically cost less than inpatient services since they do not require a patient to stay at a health care facility for an ongoing amount of time.

PREMIUM

A premium is the amount you pay for health insurance. It is, essentially, your bill for your health insurance. This money is taken out of your paycheck each pay period on a pre-tax basis.

PRIOR AUTHORIZATION

Sometimes BCBS requires that certain medical services be approved prior to you receiving them.

ROUTINE/PREVENTIVE VISIT

Routine or preventive visits are usually scheduled appointments that include a checkup, screenings, and counseling. They do not include tests or services to monitor or manage a condition or disease once it has been diagnosed. Depending on your plan type, the care provided during these visits is often covered with no out-of-pocket costs.

SPECIALIST

A specialist is a doctor who focuses on a specific area of health care. Some specialist examples include cardiologists (heart), dermatologists (skin), pulmonologists (lungs), and ophthalmologists (eyes).