

The heart of science and medicine.

2023 Benefits Guidebook



THE
University of Vermont
HEALTH NETWORK

THE
University of Vermont
MEDICAL CENTER

Welcome to Your Benefits!

The work you do every day helps us achieve our mission to improve the health of the people in the communities we serve. The University of Vermont Health Network (UVMHN) extends this mission and our culture of caring by offering you more choice! You have the flexibility to select from a full range of benefits to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement. Your Benefits Guidebook was designed to answer questions you may have about your benefits. Please take time to review the guidebook and the benefits available to you and your family and make sure you enroll before your initial enrollment/open enrollment deadline.

Your Benefits Guidebook highlights the main features of our employee benefits program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. If there is an inconsistency between the Benefits Guidebook and the legal plan documents, the plan documents are the final authority. The Company reserves the right to change or discontinue its employee benefits plans at any time.

Important Reminder: If you miss your enrollment deadline (31 days from date of hire or benefits eligibility date), you will only receive Basic Life Insurance, Headspace, Short-Term Disability, Long-Term Disability and Employee & Family Assistance Program (EFAP) coverage.

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The University of Vermont Health Network is committed to you and your family's overall health, well-being and financial protection.

Important Contacts

HR Contact Information

CONTACT	PHONE	EMAIL	WEBSITE
HR Solution Center (HRSC) Monday - Friday 8am - 5pm	844-777-0886	HRSolutionCenter@UVMHealth.org	UVMHN Benefits Website
Payroll Monday - Friday 8am - 4:30pm	802-847-3760	Payroll@UVMHealth.org	Payroll Home
Leave of Absence	844-777-0886	LOA@UVMHealth.org	Absence Management
Employee & Family Assistance Program	802-847-2827	EFAP@UVMHealth.org	EFAP Home
Employee Health	802-847-1300	EmployeeHealth@uvmhealth.org	Employee Health Home

Vendor Contact Information

COVERAGE	CONTACT	GROUP NO.	PHONE	WEBSITE
Medical	Blue Cross Blue Shield	71-5943Q	833-578-1126	myhealthtoolkitvt.com
Prescription	Navitus	NVUVMA	866-333-2757	Navitus.com
Flexible Spending Accounts (FSAs) Health Savings Account (HSA)	HealthEquity	26018	FSA: 877-924-3967 HSA: 866-346-5800	FSA General Purpose FSA Limited Purpose HealthEquity HSA
Dental	Northeast Delta Dental	7407	800-832-5700	nedelta.com
Vision	Vision Service Plan	12157661	800-877-7195	vsp.com
Short-Term Disability (STD) Long-Term Disability (LTD)	The Hartford	697296	888-716-4549	TheHartfordMyBenefits
Accident Critical Illness Hospital Indemnity	Voya	Policy No.: 71743-6	877-236-7564	Presents.voya.com/ EBRC/UVMHN
Identity Protection	Allstate Identity Protection	806	800-789-2720	myaip.com/ uvmhealthnetwork
Pet Insurance	Nationwide	UVM Health Network	Enrollments 877-738-7874 Customer Care 800-540-2016	benefits.petinsurance.com

Eligibility

To participate in The UVM Health Network (UVMHN) / UVM Medical Center (UVMHC) benefits, you must be a full or part-time employee scheduled 40-80 hours bi-weekly. We have four Benefit Eligible classifications (hours below are bi-weekly):

- **Full-Time Regular:** Hired to work 72-80 hours
- **Part-Time Regular:** Hired to work between 40-71 hours
- **Full-Time Temporary:** Hired to work in a position for a certain period of time and regularly work 72-80 hours
- **Part-Time Temporary:** Hired to work in a position for a certain period of time and regularly work 40-71 hours

We have two Non-Benefit Eligible classifications:

- **Part-Time Regular Scheduled Special (RSS):** Hired to work 8-39 hours, eligible for Combined Time Off (CTO)
- **Part-Time Per Diem:** Hired to work as needed

WHEN DOES MY COVERAGE START?

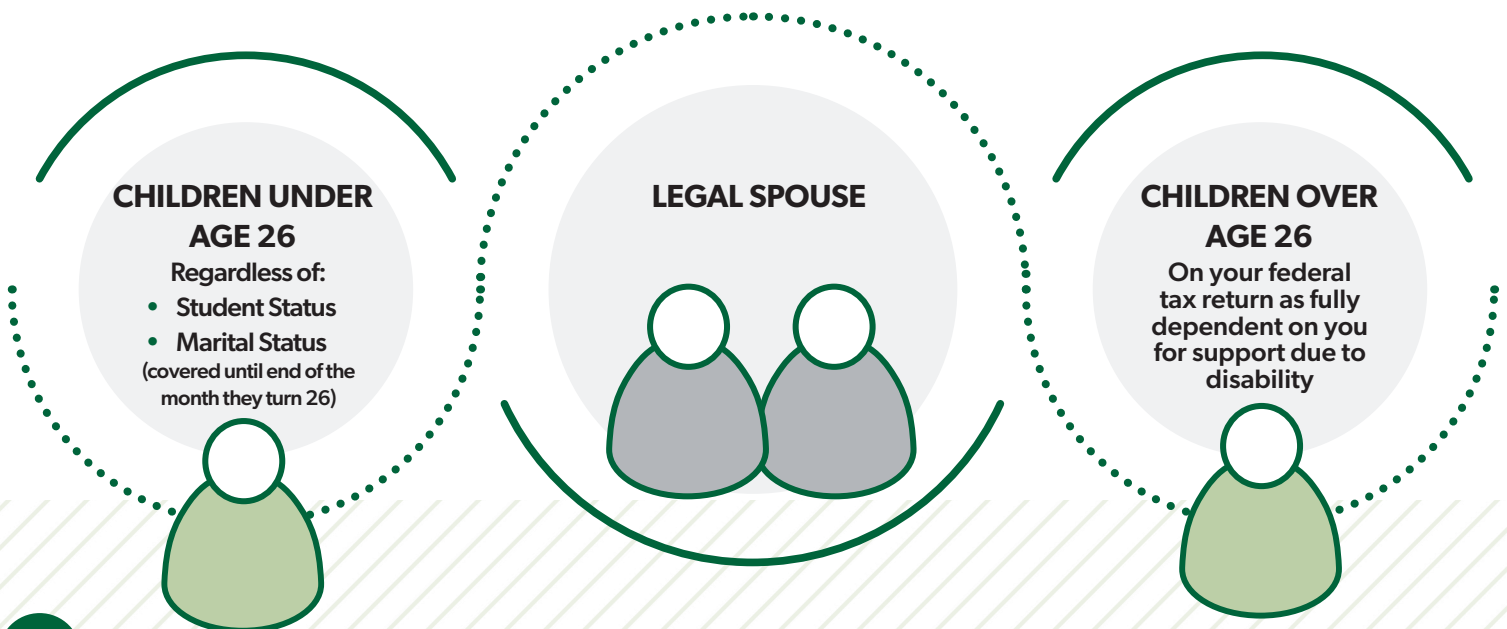
Coverage begins the first of the month following your date of hire or any change that makes you benefits-eligible. If your date of hire or benefits eligibility date is the first day of the month, your benefits begin that day.

Example:

- **Hire Date:** January 20
- **Time to Enroll in Coverage:** January 20 - February 20 (31 days)
- **Coverage Starts:** February 1

NOTE: The 31 days allowed to enroll extends after the day coverage starts. If you enroll after the coverage start date, you are responsible for any missed contributions, which will be deducted from your paycheck.

You may also enroll your eligible dependents for coverage. If you enroll in benefits, you can cover your:



Eligible Dependents – Dependent Verification

If you enroll your dependent(s), UVMHN requires you to provide documents to verify your dependents eligibility. The below chart lists the dependent verification documents required for each eligible dependent. You can scan and upload the dependent verification documents to [Workday](#) or call the HR Solution Center at 844-777-0886 for assistance.

DATE OF HIRE OR BENEFIT ELIGIBILITY DATE

Dependent Verification documents must be provided within 31 days of enrolling.

OPEN ENROLLMENT

Dependent Verification documents must be provided before the start of the next calendar year.

DUAL COVERAGE

Dual coverage is not allowed, you can only be covered by one UVMHN medical plan.

For example:

- If you and your spouse work at the same or different UVMHN affiliates and your spouse covers you under their medical plan, you cannot enroll in medical.
- If your spouse covers you and your family under medical, you can cover yourself, your spouse and your family under dental.

ELIGIBLE DEPENDENTS	DEPENDENT VERIFICATION DOCUMENTS
Legal Spouse	Marriage Certificate or Copy of the first 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
Adopted Child	Adoption Record or Placement for Adoption document from Court
Stepchild	Copy of your Marriage Certificate and Child's Birth Certificate
Legal Guardianship of children under age 26	Court Order or Legal Guardianship Document
Child Over Age 26 on your federal tax return as fully dependent on you for support due to disability	Birth Certificate and Overage Incapacitated Dependent Verification Form completed by the employee and the dependent's physician

PAYING FOR COVERAGE

The UVMHN Employee Welfare Benefits Plan satisfies the requirements for a Cafeteria Plan under Section 125 of the Internal Revenue Code. This allows you to pay for certain benefits on a pre-tax basis, which reduces your taxable income and you do not pay FICA, Federal or State income taxes on the pre-tax deductions.

In order to maintain our Section 125 Cafeteria Plan, we must follow the Internal Revenue Code requirements, which include complying with benefits eligibility, enrollment and qualifying life event rules.

Changing Benefits After Enrollment

During the year, you cannot make changes to your benefits unless you have a Qualified Life Event. If you do not make changes to your benefits within 31 days of the Qualified Life Event or 60 days for Qualified Life Events noted with an * in the chart below, you will have to wait until the next annual Open Enrollment period to make changes, unless you experience another Qualified Life Event.

IRS QUALIFIED LIFE EVENT	EVENTS	CHANGES APPLY TO	TIME ALLOWED TO MAKE CHANGES	EFFECTIVE DATE OF CHANGE	TIMELINE EXAMPLES
Open Enrollment (OE)	Annual opportunity to enroll, cancel, or change benefit elections	<ul style="list-style-type: none"> - Employee - Spouse - Eligible Dependent(s) 	Elections/Changes must be made by the last day of Open Enrollment.	January 1	OE Period: 11/15 - 11/30 Coverage starts 1/1
Loss of Coverage/ Eligibility Under Another Group Plan	<ul style="list-style-type: none"> - Employment Change - Divorce/ Annulment/Legal Separation - Death of Spouse - Child under age 26 loses coverage - Child loses coverage due to turning age 26 allows them to enroll in their own coverage, if applicable through their spouse, employer, the health care exchange or state/federal programs 	<ul style="list-style-type: none"> - Employee - Spouse - Dependent(s) 	31 days after loss of coverage/eligibility	First of month following loss of coverage/eligibility	Coverage ends on 2/15 Enroll 2/16 - 3/19 Coverage starts on 3/1
Gain Other Coverage	Gain coverage through spouse/parent as a result of new hire enrollment, open enrollment, employment change	<ul style="list-style-type: none"> - Employee - Spouse - Dependent(s) 	31 days after gain in coverage	End of month in which coverage is gained	Coverage starts on 3/1 Cancel coverage 3/1 - 4/1 Coverage ends on 2/28
Marriage	Get married	<ul style="list-style-type: none"> - Spouse - Dependent(s) 	31 days after marriage	First of month following marriage	Date of Marriage 3/10 Enroll 3/11 - 4/11 Coverage starts on 4/1





IRS QUALIFIED LIFE EVENT	EVENTS	CHANGES APPLY TO	TIME ALLOWED TO MAKE CHANGES	EFFECTIVE DATE OF CHANGE	TIMELINE EXAMPLES
Family Status Change*	<ul style="list-style-type: none"> - Birth of Child - Adoption - Placement for Adoption - Legal Guardianship Appointment 	<ul style="list-style-type: none"> - Spouse - Dependent(s) 	<p>60 days after Family Status Change applies to medical only</p> <p>All other benefits must be changed 31 days after the Family Status Change</p>	<p>Important Reminder</p> <p>Birth of Child: The child is added for the first 60 days at no charge. You must call the HRSC to add child to coverage beyond 60 days.</p> <p>Adoption/ Legal Guardianship: You must call the HRSC to add child at no charge for the first 60 days.</p>	<p>Family Status Change 5/5</p> <p>Enroll 5/6 - 7/5</p> <p>Coverage starts 5/5</p> <p>Start paying for coverage 7/5</p>
Loss of Coverage* Medicaid Children's Health Insurance Program (CHIP)	Medicaid or CHIP coverage terminates	<ul style="list-style-type: none"> - Employee - Eligible Dependent(s) 	60 days after loss of coverage	First of month following loss of coverage	<p>Date of Loss 7/14</p> <p>Enroll 7/16 - 9/13</p> <p>Coverage starts on 8/1</p>
Become Eligible for Premium Assistance* Medicaid Children's Health Insurance Program (CHIP)	Become eligible for premium assistance under Medicaid or CHIP	<ul style="list-style-type: none"> - Employee - Eligible Dependent(s) 	60 days after becoming eligible for premium assistance	First of month following gain in premium assistance	<p>Eligibility Date 9/22</p> <p>Cancel Coverage 9/23 - 11/22</p> <p>Coverage ends on 9/30</p>

Consistency Requirement: Your change in election must be consistent with the change in your circumstances.

How to Enroll

1. REVIEW YOUR OPTIONS

Review your Benefits Guidebook and go to the [UVMHN Benefits Website](#) to use the online tools/resources to help you decide which options work best for you and your family.

2. GET DEPENDENT VERIFICATION DOCUMENTS

If enrolling for the first time or adding dependents due to a Qualified Life Event, you will need your dependents Date of Birth and Social Security Number. You will also need to upload the dependent verification documents required into [Workday](#) within 31 days (see page 5).

3. ENROLL IN WORKDAY

Workday is the cloud-based HR, Payroll and Benefits system for UVMHN. Need help logging into [Workday](#)? Call the IS Helpdesk at 802-847-1414. Need help using [Workday](#)? Call the HR Solution Center at 844-777-0886.

4. Verify & Save or Print

Verify your benefit elections are correct before submitting. Save or print a copy of your benefit elections for your records.

5. Did You Upload Your Documents?

If documents are required to verify your dependents' eligibility, they must be uploaded to [Workday](#) within 31 days (see page 5). **IMPORTANT:** If you do not upload the dependent verification documents within 31 days, your dependent(s) will be removed from your coverage.

6. View Your Payslip

It is important to view your payslip in [Workday](#) to confirm your pay and benefit deductions are correct.

THE HR SOLUTION CENTER IS READY TO ANSWER YOUR QUESTIONS!

The HR Solution Center is your first stop for benefits questions.

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

PAYCHECK OR TAX WITHHOLDING QUESTIONS?

Payroll is available to answer your questions.

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

ACCESS WORKDAY ON THE GO

Go to [Workday](#), click your profile picture (top right), click My Account, click Organization ID and scan the QR code to sign in from your phone.

OR

Download the Workday mobile app and use Organization ID: **uvmhealth** to connect.



Medical



UVMHN offers four medical plans to meet the diverse needs of our employees and their families. Answer 4 questions using the Benefits Decision Support Tool (PLANselect) to help you choose the medical plan that provides the best value and lowest overall cost! Click [PLANselect](#) to get started!

Blue Cross Blue Shield (BCBS) administers our medical plans. The BCBS National Network includes more than 95% of physicians and 96% of hospitals. Which means you have access to in-network providers across the United States!

Referrals are not required to receive care and you will save money when you use UVMHN facilities and providers. The choice is yours!

Parts of Your Medical Plan

- **Preventive Care** — Covered in full when you use in-network providers. Physical Exams, Immunizations, Pelvic Exams, Pre-natal Care, tests for Blood Pressure, Diabetes and Cholesterol. Cancer Screenings include Mammograms and Colonoscopy.
- **Annual Deductible** – The amount you pay each year for eligible in-network and out-of-network services before the plan begins to pay.
- **Annual Out-of-Pocket Limit** – The most you could pay in a year for covered services. After you reach this limit, the plan will usually pay the full cost of covered services for the remainder of the year.
- **Copays** – A fixed amount you pay for certain health care services, for example \$25. Copays do not count toward your deductible but they count toward your annual out-of-pocket limit.
- **Coinsurance** – Once you've met your deductible, you and the plan share the cost of care, which is calculated as a percentage, for example 20%.



BlueCross BlueShield

BCBS National Network

All four medical plans have three tiers of coverage:

- **UVMHN Facilities & Providers (Tier 1 / Domestic Network)** - When you use our Tier 1/Domestic Network, you will have lower out-of-pocket costs. All UVMHN facilities and providers are contracted with BCBS.
- **BCBS Facilities & Providers (Tier 2 / In-Network)** - You have access to the BCBS national network. If a facility or provider participates with BCBS in any state, they are in-network.
- **Non-Participating Facilities & Providers (Tier 3 / Out-of-Network)** - You will pay the most if you use an out-of-network facility/provider. They are not contracted with BCBS.

EMBEDDED VS. AGGREGATE DEDUCTIBLE

The UVMHN 250 & 400 plans have an embedded family deductible. The plan begins to pay when one member of the family reaches their individual deductible. The HDHP 1500 & 3000 plans have an aggregate family deductible. If you have more than one person enrolled in your HDHP plan, you must meet the full family deductible before the plan pays. The IRS rules for qualified high deductible health plans include minimum/maximum deductible amounts and specify that individual deductibles cannot apply.

Medical Plan Comparison

You can seek care from any provider without a referral. The choice is always yours! Your health care dollar will go further when you use the Tier 1/Domestic Network, which includes all UVMHN facilities and providers. Click on the medical plan names (250 Plan, 400 Plan, HDHP 1500, HDHP 3000) in the chart to view the Summary of Benefits & Coverage (SBC).

	PREFERRED PROVIDER ORGANIZATION (PPO)							
	Tier 1 / Domestic		250 Plan		Tier 1 / Domestic		400 Plan	
	NETWORK	IN NETWORK	OUT NETWORK	NETWORK	IN NETWORK	OUT NETWORK		
General Medical Expenses								
Coinsurance	5%	10%	30%	5%	10%	30%		
Deductible	\$250/\$750		\$500/\$1,500	\$400/\$1,200		\$800/\$2,400		
Out-of-Pocket Limit	\$1,500/\$4,500		\$2,000/\$6,000	\$1,700/\$5,100		\$2,300/\$6,900		
Preventive Care	No Charge	No Charge	30% after ded	No Charge	No Charge	30% after ded		
Primary Care	No Charge	\$10	30% after ded	No Charge	\$10	30% after ded		
Specialist	\$25	\$25	30% after ded	\$25	\$25	30% after ded		
HSA Eligible	No			No				
HSA Funding	No			No				
Chiropractic Care (20 visits)	\$25	\$25	30% after ded	\$25	\$25	30% after ded		
Acupuncture	\$25	\$25	30% after ded	\$25	\$25	30% after ded		
Maternity Office Visit	\$10	\$10	30% after ded	\$10	\$10	30% after ded		
Outpatient Care								
Outpatient Behavioral Health Services Substance Use Disorder Services	No Charge	\$10	30% after ded	No Charge	\$10	30% after ded		
Outpatient Therapy Physical/Occupational/Speech	No Charge	\$25	30% after ded	No Charge	\$25	30% after ded		
Outpatient Lab & X-rays	No Charge	10% after ded	30% after ded	No Charge	10% after ded	30% after ded		
Imaging CT/MRI/PET Scans	5% after ded	10% after ded	30% after ded	5% after ded	10% after ded	30% after ded		
Outpatient Surgery Facility Fee	5% after ded	10% after ded	30% after ded	5% after ded	10% after ded	30% after ded		
Outpatient Surgery Physician/Surgeon Fees	5% after ded	10% after ded	30% after ded	5% after ded	10% after ded	30% after ded		
Emergency Services								
Emergency Room Waived if admitted	\$50 Copay			\$50 Copay				
Ambulance Must meet emergency criteria	No Charge			No Charge				
Urgent Care	\$25			\$25				
Inpatient								
Hospital Stay Includes Maternity Delivery & Newborn Services, Labs, Scans, X-rays	5% after ded	10% after ded	30% after ded	5% after ded	10% after ded	30% after ded		
Inpatient Services Behavioral Health Substance Use Disorder	5% after ded	10% after ded	30% after ded	5% after ded	10% after ded	30% after ded		
Other Benefits								
Routine Eye Exam 1 Every 2 Years	No Charge		Not Covered	No Charge		Not Covered		
	BCBS Providers Only			BCBS Providers Only				





	PREFERRED PROVIDER ORGANIZATION (PPO)					
	Tier 1/Domestic	HDHP 1500		Tier 1/Domestic	HDHP 3000	
	NETWORK	IN NETWORK	OUT NETWORK	NETWORK	IN NETWORK	OUT NETWORK
General Medical						
Coinsurance	10%	20%	30%	10%	20%	0%
Deductible	\$1,500/\$3,000		\$3,000/\$6,000	\$3,000/\$6,000		\$6,000/\$12,000
Out-of-Pocket Limit	\$5,000/\$10,000		\$5,000/\$10,000	\$6,000/\$12,000		\$6,000/\$12,000
Preventive Care	No Charge	No Charge	30% after ded	No Charge	No Charge	0% after ded
Primary Care	10% after ded	20% after ded	30% after ded	10% after ded	20% after ded	0% after ded
Specialist	10% after ded	20% after ded	30% after ded	10% after ded	20% after ded	0% after ded
HSA Eligible	Yes			Yes		
HSA Funding	\$500/\$1,000			\$1,000/\$2,000		
Chiropractic Care (20 visits)	10% after ded	20% after ded	30% after ded	10% after ded	20% after ded	0% after ded
Acupuncture	10% after ded	20% after ded	30% after ded	10% after ded	20% after ded	0% after ded
Maternity Office Visit	No Charge	No Charge	30% after ded	No Charge	No Charge	0% after ded
Outpatient Care						
Outpatient Behavioral Health Services Substance Use Disorder Services	10% after ded	20% after ded	30% after ded	10% after ded	20% after ded	0% after ded
Outpatient Therapy Physical/Occupational/Speech	10% after ded	20% after ded	30% after ded	10% after ded	20% after ded	0% after ded
Outpatient Lab & X-rays	10% after ded	20% after ded	30% after ded	10% after ded	20% after ded	0% after ded
Imaging CT/MRI/PET Scans	10% after ded	20% after ded	30% after ded	10% after ded	20% after ded	0% after ded
Outpatient Surgery	10% after ded	20% after ded	30% after ded	10% after ded	20% after ded	0% after ded
Outpatient Surgery Physician/Surgeon Fees	10% after ded	20% after ded	30% after ded	10% after ded	20% after ded	0% after ded
Emergency Services						
Emergency Room Waived if admitted	10% after ded			10% after ded		
Ambulance Must meet emergency criteria						
Urgent Care						
Inpatient						
Hospital Stay Includes Maternity Delivery & Newborn Services, Labs, Scans, X-rays	10% after ded	20% after ded	30% after ded	10% after ded	20% after ded	0% after ded
Inpatient Services Behavioral Health Substance Use Disorder	10% after ded	20% after ded	30% after ded	10% after ded	20% after ded	0% after ded
Other Benefits						
Routine Eye Exam 1 every 2 years	100%	100%	Not Covered	100%	100%	Not Covered
	BCBS Providers Only			BCBS Providers Only		

Prescription Drug Plans

Prescription drug coverage is included with all four medical plans. Medical and prescription drug coverage cannot be purchased separately. Navitus administers our prescription drug plan, you will receive a separate ID card from Navitus.

	250 & 400 PLAN		HDHP 1500 & 3000	
Preventive Drugs	Covered as a copay based on formulary tier		Certain Preventive Drugs are covered as a copay based on formulary tier (deductible does not apply)	
Pharmacy	Network Pharmacy		Copays apply after deductible (for all other drugs) 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 Network - Retail Pharmacy				
Tier 1	\$10	\$30	\$10	\$30
Tier 2	\$30	\$90	\$30	\$90
Tier 3	\$50	\$150	\$50	\$150
Non-Participating Pharmacy				
All Tiers	Covered at 50%		Not Covered	

Specialty Drugs

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. We have a dedicated team of pharmacists and patient care coordinators to help navigate access to these medications through the specialty pharmacy.

Prescriptions for specialty medications must be filled at the UVMHN Specialty Pharmacy. If the UVMHN Specialty Pharmacy cannot fill your prescription, they will coordinate with you to get the prescription you need. Your cost depends on which tier the specialty drug is in, as noted above.

A clinical pharmacist is available 24 hours a day, 7 days a week.

Phone: 802-847-3353 or 800-284-6630 Option 6

Email: specialtypharmacy@uvmhealth.org

Save Time & Money

UVMHN MAIL ORDER PHARMACY

If you are taking prescription drugs to manage a chronic condition such as asthma, high blood pressure, diabetes and other conditions, the mail order pharmacy can make it easier for you and your doctor.

- Convenient delivery of your prescription medications to a location of your choice
- It's easy and with a 90-day supply you have fewer refills
- Free refill reminders by phone, text or email

To sign up call the mail order pharmacy at 802-847-3784 from 8:30am - 5pm.

All you need is your name, date of birth, address, phone number, list of allergies, and insurance information. Register for our **mobile app** and manage your prescriptions from your mobile device.



HOW AN HDHP WORKS

Under the HDHP 1500 and HDHP 3000 plans, you will be responsible for the cost of any medical care, services, or prescriptions up to the deductible. After meeting the deductible, you will pay coinsurance for medical care and services. A copay will apply for any prescriptions after the deductible is met except for certain preventive drugs. Click the [Preventive Drug List](#) link below to view the full list.

EXAMPLE:

You have an office visit with your in-network 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 at a UVMHN 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**
- Deductible\$1,500
- Coinsurance 10%\$202.60
- Assumes single coverage under the HDHP 1500 Plan with no other expenses in the calendar year

EXAMPLE:

You are prescribed a drug that is not on the HDHP [Preventive Drug List](#) 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**



Health Savings Account (HSA)

A Health Savings Account (HSA) is a personal savings account you can use to pay for eligible health care expenses with pre-tax dollars — now or in the future. Once you're enrolled in the HSA, you'll receive a **HealthEquity** debit card to help manage your health care dollars. Your HSA can be used for your spouse and dependents' eligible expenses, even if they are not enrolled in your HDHP.

How an HSA Works



ELIGIBILITY

You must be enrolled in the HDHP 1500 or HDHP 3000 Plan to have an HSA. See if you qualify for an HSA below.

You must re-enroll in the HSA - it does not roll over automatically.

CONTRIBUTIONS - UVMHN & YOUR CONTRIBUTIONS COMBINED MAY NOT EXCEED THE IRS ANNUAL MAXIMUMS

HDHP 1500
UVMHN contributes: \$500 (Employee Only) | \$1,000 (Family)

HDHP 3000
UVMHN contributes: \$1,000 (Employee Only) | \$2,000 (Family)



If you will be 55 or older by the end of the calendar year, you can make an additional \$1,000 catch-up contribution. **You contribute** on a pre-tax basis and can change how much you contribute from each paycheck up to the annual IRS maximum of \$3,850 if you enroll in single coverage or \$7,750 if you enroll in family coverage.



ELIGIBLE EXPENSES

You may use your HSA funds to cover Medical, Dental, Vision and Prescription Drug expenses incurred by you and your eligible family members.

USING YOUR HSA

Use your **HealthEquity** debit card to pay for eligible expenses or save your HSA money for the future and pay for **HSA Eligible Expenses** out-of-pocket.



YOUR HSA IS ALWAYS YOURS — NO MATTER WHAT

One of the best features of an HSA is that any money left in your account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave UVMHN or retire, your HSA goes with you!



DO YOU QUALIFY?

Enrolling 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 collecting Social Security benefits?
- Do you have other health coverage other than UVMHN coverage (i.e. non-HDHP, Medicare, Tri-Care, VA benefits, FSA)?
- Can you be claimed as a dependent on another person's tax return?

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 the HDHP 1500 or HDHP 3000 plan.

HSA = 3 TAX ADVANTAGES!

- **Tax-Free** Contributions - Reduce Your Taxable Income
- **Tax-Free** Withdrawals - For Eligible Expenses
- **Tax-Free** Growth - Investment Earnings

CONTRIBUTIONS

UVMHN helps you save more by contributing to your HSA! You can contribute tax-free from your paycheck to build your savings for health care expenses now or even into retirement. The UVMHN contribution is based on the plan you choose and if it is single or family coverage. The UVMHN contribution is always yours even if you leave UVMHN or retire.

UVMHN CONTRIBUTION AMOUNTS

- **HDHP 1500 Single:** \$500
- **HDHP 1500 Family:** \$1,000
- **HDHP 3000 Single:** \$1,000
- **HDHP 3000 Family:** \$2,000

UVMHN will deposit half of their contribution in January and the remaining contributions will be deposited evenly in April, July and October. Employees who enroll after January 1 will receive prorated amounts. See the [UVMHN HSA Contributions](#) schedule on page 51.

NOTE: The UVMHN contributions plus your contributions **may not exceed** the annual IRS limits.

HSA ELIGIBLE EXPENSES

Examples include:

- Deductible, Copay, Coinsurance
- Medical, Dental, Vision
- Prescription Drugs
- Over-the-Counter Medicine – prescription not required
- Acupuncture & Chiropractic
- LASIK Eye Surgery
- Long-Term Care Insurance
- COBRA Premiums

Click the HSA ELIGIBLE EXPENSES link above for a full list.

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 HSA funds over \$1,000. For more information on your investment options, fees, and more visit [Investing Your HSA](#).

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.

YOU OWN YOUR HSA. AS AN HSA OWNER, YOU:

- Decide the amount to contribute to the HSA 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 in a timely manner, you may pay additional tax and/or penalties to the IRS. Questions should be directed to your tax advisor.



Medical Rates

UVMMC Staff - Full-Time (72-80 Hours)

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST	ANNUAL COST (YOU + UVMHN)
Medical				
Premier 250	Your Cost	UVMHN		
1 Person	\$81.80	\$327.22	\$2,127	\$10,635
2 Person	\$163.65	\$654.61	\$4,255	\$21,275
Family	\$216.82	\$867.28	\$5,637	\$28,186
Premier 400	Your Cost	UVMHN		
1 Person	\$78.27	\$313.08	\$2,035	\$10,175
2 Person	\$156.58	\$626.33	\$4,071	\$20,356
Family	\$207.45	\$829.80	\$5,394	\$26,969
HDHP 1500	Your Cost	UVMHN		
1 Person	\$64.53	\$293.95	\$1,678	\$9,320
2 Person	\$129.09	\$588.07	\$3,356	\$18,646
Family	\$171.15	\$779.69	\$4,450	\$24,722
HDHP 3000	Your Cost	UVMHN		
1 Person	\$59.71	\$271.98	\$1,552	\$8,624
2 Person	\$119.44	\$544.12	\$3,105	\$17,253
Family	\$158.50	\$722.04	\$4,121	\$22,894

UVMMC Staff - Part-Time 1 (60-71 Hours)

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST	ANNUAL COST (YOU + UVMHN)
Medical				
Premier 250	Your Cost	UVMHN		
1 Person	\$122.70	\$286.32	\$3,190	\$10,635
2 Person	\$245.48	\$572.79	\$6,382	\$21,275
Family	\$325.23	\$758.87	\$8,456	\$28,186
Premier 400	Your Cost	UVMHN		
1 Person	\$117.40	\$273.95	\$3,052	\$10,175
2 Person	\$234.87	\$548.04	\$6,107	\$20,356
Family	\$311.17	\$726.08	\$8,091	\$26,969
HDHP 1500	Your Cost	UVMHN		
1 Person	\$100.37	\$258.11	\$2,610	\$9,320
2 Person	\$200.80	\$516.36	\$5,221	\$18,646
Family	\$266.23	\$684.60	\$6,922	\$24,722
HDHP 3000	Your Cost	UVMHN		
1 Person	\$92.88	\$238.82	\$2,415	\$8,624
2 Person	\$185.80	\$477.77	\$4,831	\$17,253
Family	\$246.55	\$633.99	\$6,410	\$22,894

UVMMC Staff - Part-Time 2 (40-59 Hours)

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST	ANNUAL COST (YOU + UVMHN)
Medical				
Premier 250	Your Cost	UVMHN		
1 Person	\$163.61	\$245.41	\$4,254	\$10,635
2 Person	\$327.31	\$490.96	\$8,510	\$21,275
Family	\$433.63	\$650.46	\$11,274	\$28,186
Premier 400	Your Cost	UVMHN		
1 Person	\$156.54	\$234.81	\$4,070	\$10,175
2 Person	\$313.16	\$469.75	\$8,142	\$20,356
Family	\$414.90	\$622.35	\$10,787	\$26,969
HDHP 1500	Your Cost	UVMHN		
1 Person	\$136.22	\$222.25	\$3,542	\$9,320
2 Person	\$272.52	\$444.64	\$7,086	\$18,646
Family	\$361.32	\$589.52	\$9,394	\$24,722
HDHP 3000	Your Cost	UVMHN		
1 Person	\$126.05	\$205.65	\$3,277	\$8,624
2 Person	\$252.15	\$411.41	\$6,556	\$17,253
Family	\$334.61	\$545.94	\$8,700	\$22,894

Decision Support Tool PLANselect

UVMHN recognizes there are many 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 guide you.

HOW DOES IT WORK

It's easy as 1 - 2 - 3! Access [PLANselect](#) from a computer or mobile device.

1. Enter your zip code.
2. Answer 4 questions
3. Review the recommended Best Value & Lowest Overall Cost options

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 listing which UVMHN medical plans would likely provide the best value and lowest overall cost to you.

WHAT DOES PLANselect DO?

- Helps you choose the best medical plan for you and your family!
- Evaluates your overall cost, including premiums and out-of-pocket expenses (deductibles, copays and coinsurance).
- Recommends medical plans based on your answers.

Click [PLANselect](#) to get help choosing a medical plan now!

Things to Consider When Choosing a Medical Plan

WHAT IS YOUR RISK TOLERANCE?

DO YOU PREFER TO PAY MORE FOR COVERAGE (VIA YOUR PAYCHECK) AND PAY LESS OUT-OF-POCKET WHEN YOU RECEIVE CARE?

This may be a good option for people who like knowing how much they will have to pay when receiving care or who use the medical and prescription plans often.

DO YOU PREFER TO PAY LESS FOR COVERAGE (VIA YOUR PAYCHECK) AND PAY MORE OUT-OF-POCKET WHEN YOU RECEIVE CARE?

IF SO, YOU CAN SET-ASIDE MONEY TAX-FREE WITH A HEALTH SAVINGS ACCOUNT (HSA) TO HELP PAY FOR HEALTH CARE.

You may be more comfortable with this option if you are the type of person who pays less for auto insurance and pays a higher deductible when you have a claim. This is also a good option for people who want to save tax-free money for future medical expenses, even into retirement!

HSA = 3 Tax Advantages!

1. **Tax-Free** Contributions
2. **Tax-Free** Growth
3. **Tax-Free** Distributions (qualified expenses)



Dental

Your smile can be a window to your health. Sometimes the early signs of disease are visible to dentists when patients open wide. Our three dental plans cover preventive care 100%. Choose the plan that works best for you and your family and schedule your dental exam!

BENEFIT PLAN	DESCRIPTION	BASIC	CORE	BUY-UP
Waiting Period	There is no waiting period for services, benefits are available on the first day of coverage.			
Network	Two Networks PPO: Dentists who have agreed to accept reduced fees for covered services, which reduces 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	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
Orthodontia Coverage	Basic Plan: Children to age 19 Core & Buy-Up Plans: Adults & Children	50%	50%	65%
Lifetime Maximum for Orthodontics	Per person, see covered persons for each plan above	\$1,000	\$1,500	\$2,500

Go to [NEDelta.com](https://www.nedelta.com) to find a dentist, view claims, benefits, print ID cards and more!



Dental Rates

UVMMC Staff - Full-Time (72-80 Hours)

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST	ANNUAL COST (YOU + UVMHN)
Dental				
Basic	Your Cost	UVMHN		
1 Person	\$4.36	\$13.07	\$113	\$453
2 Person	\$7.90	\$23.71	\$205	\$822
Family	\$14.39	\$43.16	\$374	\$1,496
Core	Your Cost	UVMHN		
1 Person	\$5.01	\$15.02	\$130	\$521
2 Person	\$9.08	\$27.25	\$236	\$945
Family	\$16.54	\$49.61	\$431	\$1,720
Buy-up	Your Cost	UVMHN		
1 Person	\$5.36	\$16.07	\$139	\$557
2 Person	\$9.78	\$29.34	\$254	\$1,017
Family	\$17.82	\$53.45	\$463	\$1,853

UVMMC Staff - Part-Time 1 (60-71 Hours)

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST	ANNUAL COST (YOU + UVMHN)
Dental				
Basic	Your Cost	UVMHN		
1 Person	\$6.10	\$11.33	\$159	\$453
2 Person	\$11.06	\$20.55	\$288	\$822
Family	\$20.14	\$37.41	\$524	\$1,496
Core	Your Cost	UVMHN		
1 Person	\$7.01	\$13.02	\$182	\$521
2 Person	\$12.72	\$23.62	\$331	\$945
Family	\$23.15	\$42.99	\$602	\$1,720
Buy-up	Your Cost	UVMHN		
1 Person	\$7.50	\$13.93	\$195	\$557
2 Person	\$13.69	\$25.43	\$356	\$1,017
Family	\$24.94	\$46.32	\$649	\$1,853

UVMMC Staff - Part-Time 2 (40-59 Hours)

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST	ANNUAL COST (YOU + UVMHN)
Dental				
Basic	Your Cost	UVMHN		
1 Person	\$13.07	\$4.36	\$340	\$453
2 Person	\$23.71	\$7.90	\$616	\$822
Family	\$43.16	\$14.39	\$1,122	\$1,494
Core	Your Cost	UVMHN		
1 Person	\$15.02	\$5.01	\$391	\$521
2 Person	\$27.25	\$9.08	\$708	\$945
Family	\$49.61	\$16.54	\$1,290	\$1,720
Buy-up	Your Cost	UVMHN		
1 Person	\$16.07	\$5.36	\$418	\$557
2 Person	\$29.34	\$9.78	\$763	\$1,017
Family	\$53.45	\$17.82	\$1,390	\$1,853



Vision

Sight is one of the life's most precious gifts. UVMHN wants to help keep your eyes healthy so you can keep doing the things you enjoy most! Did you know eye exams can help detect health conditions such as diabetes?

VSP helps keep your eyes healthy and offers you more ways to save! Pay less when using a VSP provider. Costco Optical eyeglasses and contacts are covered in-network. Save with additional **Discounts!**

NOTE: Costco Optical offers eye exams, but the optometrist may not be a VSP provider. Go to [VSP.com](https://www.vsp.com) to find an eye doctor or call VSP at 800-877-7195.

	VSP	
	Core Plan	Buy-up Plan
	You Pay	You Pay
Exam	\$20 copay	\$10 copay
Frames	\$130 allowance \$150 allowance for featured frame brands 20% discount on any amount over allowance	\$175 allowance \$195 allowance for featured frame brands 20% discount on any amount over allowance \$95 Costco allowance
Lenses	Single Vision, Lined Bifocal, and Lined Trifocal Polycarbonate lenses for dependent children	Single Vision, Lined Bifocal, and Lined Trifocal Polycarbonate lenses for dependent children
Contacts instead of Frames/Lenses	\$130 allowance for contacts and contact lens exam	\$175 allowance for contacts and contact lens exam
Benefit Frequency		
Exams	Every Calendar Year	Every Calendar Year
Lenses	Every Other Calendar Year	Every Calendar Year
Frames	Every Other Calendar Year	Every Calendar Year
Contacts	Every Calendar Year	Every Calendar Year
Progressive Lenses	\$0 - \$160	\$0 - \$160
Discounts on scratch resistance, anti-glare, and tinted lenses	35% - 40%	35% - 40%

Vision Rates

UVMMC Staff - Full-Time (72-80 Hours)

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST
Vision			
Core	Your Cost	UVMHN	
1 Person	\$2.18	\$0.00	\$57
2 Person	\$4.38	\$0.00	\$114
Family	\$7.04	\$0.00	\$183
Buy-up	Your Cost	UVMHN	
1 Person	\$3.59	\$0.00	\$93
2 Person	\$7.19	\$0.00	\$187
Family	\$11.22	\$0.00	\$292

UVMMC Staff - Part-Time 1 (60-71 Hours)

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST
Vision			
Core	Your Cost	UVMHN	
1 Person	\$2.18	\$0.00	\$57
2 Person	\$4.38	\$0.00	\$114
Family	\$7.04	\$0.00	\$183
Buy-up	Your Cost	UVMHN	
1 Person	\$3.59	\$0.00	\$93
2 Person	\$7.19	\$0.00	\$187
Family	\$11.22	\$0.00	\$292

UVMMC Staff - Part-Time 2 (40-59 Hours)

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST
Vision			
Core	Your Cost	UVMHN	
1 Person	\$2.18	\$0.00	\$57
2 Person	\$4.38	\$0.00	\$114
Family	\$7.04	\$0.00	\$183
Buy-up	Your Cost	UVMHN	
1 Person	\$3.59	\$0.00	\$93
2 Person	\$7.19	\$0.00	\$187
Family	\$11.22	\$0.00	\$292



Flexible Spending Accounts (FSAs)

FSAs allow you to pay for eligible expenses using tax-free dollars. You decide the amount you will need for health care expenses for the year. This amount is divided equally by the number of pay periods in the year. This is the amount that will be deducted pre-tax from your paycheck. If you elect a Health Care FSA during open enrollment, the full amount you elected will be available to use January 1 and you can use your **HealthEquity** debit card to pay for eligible health care expenses. For example, if you elect \$2,000 and are paid bi-weekly, \$76.92 will be deducted from each paycheck ($2000 / 26 = 76.92$). The full \$2,000 is available to use starting January 1. **NOTE:** Dependent Care FSA funds are not available January 1. You must contribute and have an available balance to get reimbursed for expenses.

HEALTH CARE FSA - GENERAL PURPOSE

Contribute up to \$3,050 per year, pre-tax, to pay for deductibles copays, prescriptions, diagnostic tests, contact lenses and eyeglasses.

Eligible Expenses

Health Care FSA - Limited Purpose

Those enrolled in the HDHP 1500 & 3000 plans can contribute up to \$3,050 per year, pre-tax, to pay for **eligible dental and vision expenses**.

DEPENDENT CARE FSA

Contribute up to \$5,000 per year (\$2,500 if married and filing separate tax returns), pre-tax, to pay for **eligible dependent care expenses** so that you or your spouse may work or attend school full-time. A qualifying dependent may be a child under age 13, a disabled spouse, or an older parent in eldercare. Debit card not available.



USE IT OR LOSE IT

If you do not spend all the money in your FSA by **December 31**, per IRS rules, unused dollars will be forfeited.

CARRYOVER BENEFIT - GENERAL & LIMITED PURPOSE FSA

The plan year is January 1 - December 31 and you may carryover up to \$610 of unused funds into the next plan year. The carryover amount doesn't count towards your annual contribution maximum. Any unused funds greater than \$610 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.

USING THE FSA 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 health care providers directly from your account for eligible expenses.

PLANS OFFERED:

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

CONTRIBUTIONS:

Pre-tax contributions from your paycheck for all FSAs.

HELPFUL INFORMATION:

- [Dependent Care Guide](#)
- [FSA General Purpose](#)
- [FSA Limited Purpose](#)

YOU MAY BE REQUIRED TO SUBMIT RECEIPTS FOR EXPENSES PAID USING YOUR DEBIT CARD

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

DEPENDENT CARE - GRACE PERIOD

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, 2024 to incur expenses that can be paid for using funds remaining from the 2023 plan year.

EXAMPLE:

If you have \$300 remaining at the end of the plan year (December 31, 2023), those funds will remain available for you to use for eligible expenses until March 15, 2024.

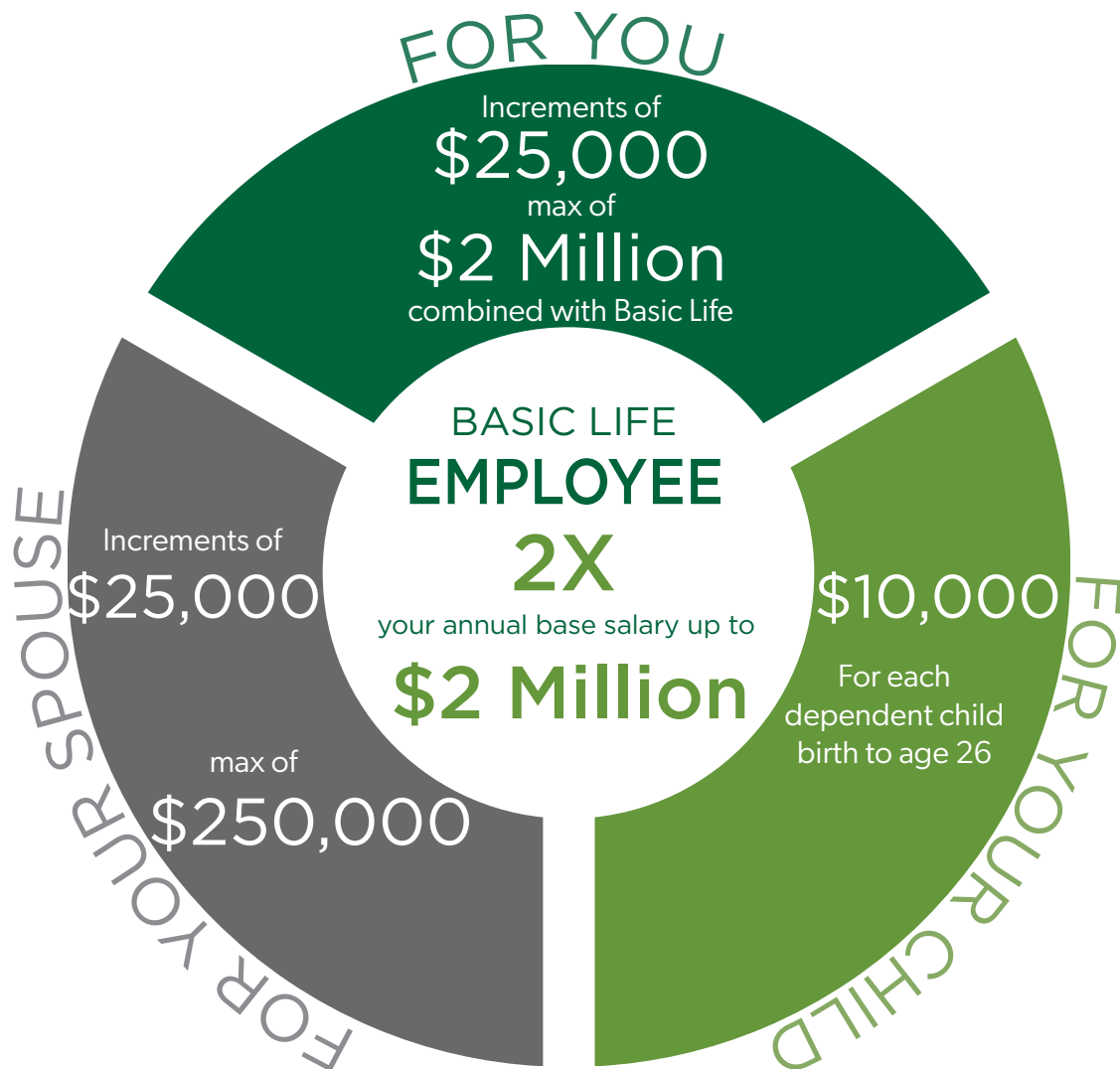
You have until May 31, 2024 to submit those 2023 eligible expenses for reimbursement.



Life Insurance

Term Life Insurance

UVMHN provides financial protection for you and your beneficiaries with *Basic Life Insurance at no cost to you. Benefit eligible employees receive 2x their annual base salary up to \$2 million. You also have the option to purchase **Additional Life Insurance for you, your spouse and your child(ren).



***BASIC LIFE:** You are automatically enrolled and coverage starts the first of the month following your date of hire or benefits eligibility date. Health information is not required.

****ADDITIONAL LIFE:** You can elect up to the Guaranteed Issue amount for yourself and your spouse and health information is not required.

Additional Life Guaranteed Issue Amounts

Employee: \$200,000

Spouse: \$50,000

ADDITIONAL LIFE INSURANCE RATES - GO TO [APPENDIX pg. 50](#)

INCREASE YOUR LIFE INSURANCE ONE TIME OPPORTUNITY!

2023 Open Enrollment Only

UVMHN is excited to offer benefit eligible employees the opportunity to purchase additional life insurance at lower rates! This is a **one-time opportunity** during the 2023 Open Enrollment period only, from November 15 – November 30, 2022.

We hope you take the time to review this information carefully as it provides additional financial protection for you and your beneficiaries.

BASIC LIFE INSURANCE

Benefit eligible employees who have Basic Life coverage in the amount of \$50,000 can enroll in the Basic Life benefit of 2x base annual salary up to \$2 million max and health information is not required.

If you enroll in the 2x Basic Life benefit any amounts over \$50,000 will be considered imputed income, which is taxable. The below example shows the imputed income (amount taxed) for this scenario.

EXAMPLE – Go to [Appendix](#) for Rates and How to Determine Imputed Income

Hourly Rate: \$20

Annual Salary: \$41,600

Annual Salary Rounded to Nearest

Thousand: \$42,000

Basic Life 2x Annual Salary: \$84,000

Amount Over \$50K: \$34,000

Employee Age: 40

Imputed Income (Amount Taxed): **\$40.56**

ADDITIONAL LIFE INSURANCE GUARANTEED ISSUE AMOUNT: INCREASED FROM \$100,000 TO \$200,000 FOR EMPLOYEE COVERAGE

EMPLOYEE COVERAGE: Benefit eligible employees who do not have additional life insurance can purchase additional life insurance up to \$200,000 max and health information **is not** required. If an employee currently has additional life insurance in an amount less than \$200,000, they can purchase additional life insurance up to the \$200,000 max and health information **is not** required.

For example, if you are a benefit eligible employee who has \$50,000 in additional life insurance, you can purchase an additional \$150,000 (up to \$200,000) and health information **is not** required.

SPOUSE COVERAGE: Benefit eligible employees who do not have additional spouse life insurance can purchase additional spouse life insurance up to \$50,000 max and health information **is not** required. If an employee currently has additional spouse life insurance in an amount less than \$50,000 they can purchase additional spouse life insurance up to the \$50,000 max and health information **is not** required.

ADDITIONAL LIFE INSURANCE AMOUNTS OVER GUARANTEED ISSUE EVIDENCE OF INSURABILITY (EOI)

Any amounts over \$200,000 for employee life coverage or over \$50,000 for spouse life coverage requires health information, referred to as Evidence of Insurability (EOI). The Hartford will review the EOI information and will approve or deny. If additional life insurance amounts are denied, you will receive the Guaranteed Issue amount of \$200,000 for employee life coverage and \$50,000 for spouse life coverage.

IMPORTANT – REVIEW YOUR BENEFICIARIES

Basic Life Insurance: Please review your beneficiaries and make any necessary changes. Once your beneficiaries are added, **enter a percentage.**

Additional Life Insurance: If you are currently enrolled or enroll for 2023, you will be able to add a separate beneficiary from your Basic Life insurance for employee coverage. You are automatically the beneficiary for spouse and child(ren) life coverage.

In [Workday](#) you can list multiple primary and contingent beneficiaries, but the total percentages **must equal 100%**. A person can be a primary or contingent beneficiary, **but not both**. If you need help verifying or updating your beneficiaries, please contact the HR Solution Center at 844-777-0886.

NOTE: After Open Enrollment, **starting November 16, 2022** you will not be able to add or update beneficiaries for life insurance **until January 1, 2023.**

IMPORTANT – PERCENTAGE MUST BE ENTERED FOR BENEFICIARIES

If no percentage is entered in [Workday](#) for your beneficiaries, it is considered “no beneficiary on file”. If there is no beneficiary on file, life claims will be paid as follows:

1. Executors or administrators of your estate
2. All to your surviving spouse
3. If your spouse does not survive you, in equal shares to your surviving children
4. If no child survives you, in equal shares to your surviving parents





Beneficiary Designation

When enrolling in [Workday](#), you can designate a beneficiary for your life insurance coverage. In the event of your death, the benefit will be paid to the beneficiaries in [Workday](#).

You can update your beneficiaries at any time in [Workday](#). It is important to review your beneficiaries and make sure you enter percentages for each beneficiary.

You are automatically the beneficiary for spouse and child life coverage.

IMPORTANT: If no percentage is entered for your beneficiaries in [Workday](#), it is considered “no beneficiary on file.” If there is no beneficiary on file, life claims will be paid as follows:

1. Executors or administrators of your estate
2. All to your surviving spouse
3. If your spouse does not survive you, in equal shares to your surviving children
4. If no child survives you, in equal shares to your surviving parents

Additional Life Insurance/AD&D

In addition to the Basic Life Insurance UVMHN provides, you can purchase Additional Life Insurance, which you pay for after-tax.

PURCHASE:

- Additional Employee Life
- Spouse Life
- Child Life

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 emailed to your work address following enrollment in [Workday](#).
- 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 70. Your coverage continues; however this means the insurance coverage is reduced by a certain percentage based on your age. This reduction applies to UVMHN paid coverage as well as any additional coverage you elect for you or your spouse. The reduction is based upon the insured person’s date of birth.

- At age 70, coverage is reduced to 65% of the coverage in place prior to age 70.
- At age 75, coverage is reduced to 50% of the coverage in place prior to age 70.

Portability/Conversion

If you leave UVMHN or become employed in a non-benefits eligible classification, you can take the coverage with you. You have the option to Port or Convert your life insurance coverage with The Hartford.

If you terminate employment or become ineligible for coverage, you will be notified by The Hartford via USPS mail on your options and the process to Port or Convert coverage. Please be aware you have 31 days from termination or change to a non-benefits eligible classification to Port or Convert life insurance.

Disability

STD & LTD

UVMHN provides additional financial protection by providing you with disability benefits at no cost. These benefits pay a portion of your pay while out of work due to a non-work illness/injury. You are automatically enrolled once you become eligible.



*Part-Time Employees

STD: 60% of base pay for employees with more than 3 years of service.

LTD: benefit for part-time employees is the same as above.

**If you are age 63+, the LTD benefit period is based on your age. If you have questions, call the HR Solution Center 844-777-0886.



Disability

Short-Term Disability (STD)

STD can be used when you are unable to perform the essential functions of your job for a period of time due to a non-work illness/injury. Reasons you may need disability could include:

- Childbirth
- Illness
- Injury (non-work related)
- Pregnancy Complications
- Surgery

Full-time employees (72-80 hours) receive after 6-months of employment and part-time employees (40-71 hours) receive after 12-months of employment.

Long-Term Disability (LTD)

If your non-work illness/injury exceeds 6-months, you may qualify for LTD benefits. Full-time employees and part-time employees receive LTD the first of the month following date of hire.

ADDITIONAL LTD COVERAGE

You can purchase additional LTD insurance equaling 6.67% of your base monthly salary. The monthly maximum of \$10,000 will still apply.

This will be paid after-tax through paycheck deductions. See the [Appendix \(pg.51\)](#) for the age-banded rates and premium calculation.

MATERNITY LEAVE

Maternity Leave is covered through the STD plan. Expectant mothers may take ante partum leave, which allows them to stop working anytime during the 2-weeks prior to their due date. The STD waiting period applies.

STD benefits are paid as follows:

- **Vaginal Birth:** 6-week max
- **C-Section:** 8-week max



MATERNITY CARE PROGRAM

- **MyHealth Planner** - Interactive App
- **Breast Pump** - FREE
 - Ameda or Medela
 - Other Brands - up to \$150 must use contracted provider
- **Lactation Support Services**
 - Consultation during hospital stay and at home
- **Educational Classes** - up to \$125
 - Breastfeeding
 - Childbirth
 - Parenting
 - Sibling

Claim Forms - [Click here](#)

Choose One

- **Car Seat** - up to \$150
- **Fitness Classes** - up to \$150
- **Help at Home** - 9 Hours
 - After baby arrives
 - Up to \$25/hour

ENROLL

Call 855-838-5897 or

[MyHealthToolkitVT.com](https://www.uvmh.org/MyHealthToolkitVT.com)

create account or log in

Go to Wellness & Click Maternity

To participate you must be enrolled in a UVMHN BCBS medical plan

Disability

STARTING A CLAIM

Needing 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. It is important to communicate with your manager about your need for a leave of absence. While you should provide as much notice as possible for an upcoming leave, you do not need to provide your manager with 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

BENEFIT PROVIDED BY:

The Hartford

CONTACT INFORMATION:

888-716-4549

GROUP NUMBER:

697296

WEBSITE:

[TheHartfordMyBenefits](https://www.thehartford.com/mybenefits)

USE WEBSITE TO:

- Start a Claim
- Check Claim Status

DISABILITY PLANS:

- Short-term Disability
- Long-term Disability

PREMIUMS:

- Paid by UVMHN

HELPFUL INFORMATION:

- [Return to Work Form \(Fitness for Duty\)](#)
- [STD Guidebook](#)
- [Long-Term Disability Summary Plan Description](#)
- [Guidance Resources](#)

EXTRA SUPPORT

WHILE ON STD/LTD CLAIM:

Ability Assist Counseling Services

Call: 800-964-3577

Visit: [Guidance Resources](#)

Organization Web ID: HLF902

Company Name Field: ABILI

Select: Ability Assist Program



403(b) Retirement Plan

One of the best ways to ensure a secure retirement is to start saving as early as possible. Our 403(b) savings plan allows you to save for retirement on a pre-tax and ROTH (after-tax) basis. You can start contributing to the plan immediately and you have the option of making pre-tax or Roth (after-tax) contributions to your account through payroll deductions. You will automatically be enrolled in the plan after six months of service with a 3% pre-tax contribution, which can be changed at any time.

Increase Your Retirement Savings With a 403(b)

TYPES OF 403(b) CONTRIBUTIONS

Basic Contribution*

Matching Contribution*

Employee Contributions

Employee contributions cannot exceed the IRS limit of

\$22,500**



Vesting

You will become 100% vested in the UVMHN Basic & Matching Contribution after 3 years of employment.

You are always 100% vested in your personal contributions and any earnings on these contributions.



If you are **AGE 50** or older by the end of the calendar year you can make an additional contribution of **\$7,500**.

***Basic Contribution:** UVMHN will contribute 3-10% of your annual compensation each pay period based on your Age + Years of Service. You do not need to contribute to receive the basic contribution.

***Matching Contribution:** If you contribute 3% or more, UVMHN will make a company match of 2%. If you contribute less than 3%, the company match will be prorated.

****We will automatically stop your contributions if you reach the IRS limit for your age.**

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 NetBenefits at 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 account.**
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.

YOUR CONTRIBUTIONS

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

Traditional pre-tax contributions are deducted from your paycheck. You pay no federal or state taxes on your before-tax contributions 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.



BENEFIT PROVIDED BY:

Fidelity

CONTACT INFORMATION:

Fidelity Retirement
Service Center
800-343-0860

FIDELITY MEETING RESERVATIONS:

800-642-7131

GROUP NUMBER:

69524

WEBSITE:

netbenefits.com/uvmhealth

RETIREMENT PLAN:

403(b)

OTHER HELPFUL INFORMATION:

- [Manage Account Online](#)
- [Summary Plan Description](#)
- [Transfer/Rollover Form](#)

YOU MAY CHANGE YOUR CONTRIBUTION AT ANY TIME

IRS CONTRIBUTION LIMITS

In 2023, the IRS contribution limit is \$22,500. If you will be 50 or older in 2023, you may make additional catch-up contributions of \$7,500. For your convenience, if you meet the age requirement, your contribution limit will automatically be extended to \$30,000 for the year.

We will automatically stop 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. If you have contributed to a 403(b) at another employer, UVMHN can assist to make sure you do not exceed the IRS annual maximum. Please contact the HR Solution Center at 844-777-0886 for more information.

EMPLOYER BASIC CONTRIBUTION

After six months of service, UVMHN will begin making employer contributions to your account. You must be full-time or part-time (.5 FTE+) to be eligible for employer contributions.

Based on your age and years of service as of December 31 of the previous year, the percentage will vary from 5% to 10% of eligible earnings. It is not necessary to make personal contributions to receive this employer basic contribution. You earn a year service when you work 1,000 hours or more in a calendar year.

YOUR AGE + YEARS OF SERVICE (POINTS) = BASIC CONTRIBUTION

- <40 points = 3%
- 41 - 59 points = 5%
- 60 - 79 points = 7%
- 80+ points = 10%

Point totals and changes to Basic contribution amounts are updated at the end of January and are not retroactive.

EMPLOYER MATCHING CONTRIBUTION

After six months of service, if you contribute 3% or more of your eligible earnings, UVMHN will make a matching contribution of 2%. You must be full-time or part-time (.5 FTE+) to be eligible for employer contributions.

If you contribute less than 3%, the matching contribution will be prorated. The matching contribution is calculated on a per pay period basis – not on annual earnings. In order to receive the full matching contribution, you must have a deferral election of 3% or more in place. If your deferral is set to 0%, you will not get a matching contribution.

VESTING

You always own any contributions you make to your retirement account. Employer contributions (basic and match) are subject to a 3-year vesting period.

If you terminate employment after reaching age 65 or die while still an employee, you will be vested in all UVMHC contributions and investment earnings on those contributions regardless of the number of years of service you have earned.

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. UVMHC has selected the T. Rowe Price Target Retirement Life Cycle Funds to serve as the default. Which fund you would default to depends on your age and expected retirement date.

REHIRE & SERVICE TIME INFORMATION

If you worked at UVMHC or any UVMHN affiliate within the past five years and have been rehired, your earlier service time will apply to the 6-month waiting period for employer contributions. You will always retain time earned towards vesting back to the network affiliation date. Please contact the HR Solution Center at 844-777-0886 if you believe this may apply to you.

EDUCATION & CONSULTATIONS

Fidelity hosts frequent on-site visits for one-on-one meetings. For your convenience, virtual appointments are also available. **Visit the intranet to view the schedule and make an appointment online at [Fidelity.com/reserve](https://www.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
- General or home loan

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 at 800-448-2542
[valic.com](https://www.valic.com)
- TIAA, Group104155
24-hour service at 800-842-2776
[tiaa.org](https://www.tiaa.org)
- AIG – Sun America, Group 1412A
800-445-7862
- Lincoln Financial, Group 0001586
800-343-0441
- MetLife, Group 1084417
800-560-5001



Wellness

Explore a New Path to Wellbeing in 2023

Exploring new routines and activities can help you identify your strengths, create healthier habits and meet new people that make life more interesting and enjoyable.



Employee Wellness is introducing new adventures for 2023 that will encourage you to find new ways to engage in your health and wellbeing. The Employee Wellness **Passport to Wellbeing** will give you the opportunity to build on your unique strengths and navigate a new path to a happier you.

New for 2023

- **Employee Wellness Passport to Wellbeing:** Complete your journey and submit the passport to be entered into the quarterly raffle for great prizes. Electronic and hard copy “passports” along with instructions will be available starting January 2023.
- **Wellness Champion Program:** Become a Wellness Champion in your unit or department today and guide your colleagues on their wellbeing journey. Email wellness@uvmhealth.org for more information.
- **Biometric Screenings:** Back by popular demand, locate your starting point with a biometric screening.
- **Employee Wellness Adventures:** Discover new ways to navigate with Employee Wellness partnerships. Keep an eye out for our offerings in collaboration with the Employee & Family Assistance Program (EFAP), The Osher Center for Integrative Health, The VT Cancer Center, Working Bridges and our Community Partners.

Find out more, find us on [Facebook](#) by searching UVM Medical Center Employee Wellness or email us at wellness@uvmhealth.org.



Headspace

Be Kind to Your Mind!



UVMHN is dedicated to supporting your overall health, well-being and happiness, which includes your emotional well-being. UVMHN provides all employees with FREE access to the Headspace app! We hope Headspace will help you bring more health and happiness to your days at work, home and everywhere in between.

About Headspace for Work

Think of Headspace as your mind's best friend. It is available for you whenever you need it, wherever you are, to help you get through tough times and find joy in every day.

Through science-backed meditation and mindfulness tools, Headspace helps you create life-changing habits to support your mental health and find a healthier, happier you.

Headspace is proven to reduce stress by 14% in just 10 days. It can also help you relax your mind in minutes, improve focus, and get the best sleep ever.

1-Minute Meditation



HOW DO I SIGN UP?

Sign Up, Log In, Finish

1. Visit the [UVMHN Headspace Enrollment](#) or scan the QR code
2. You will be asked if you have an existing account with Headspace:
 - **New Members:** answer No and create account
 - **Existing Members:** answer Yes and sign in
3. **New Members:** verify your access using your UVMHN email, you will receive two emails from Headspace
- **Existing Members:** verify your account with your UVMHN email, you will receive one email from Headspace



Download the app and get some Headspace!

- Download the Headspace app in the iOS App Store or Google Play Store



Click the links below to:

- [LESS STRESS, MORE PROGRESS](#)
- [TAKE A BREAK - BREAK A SWEAT](#)
- [PUT YOUR MIND TO BED](#)

Employee & Family Assistance Program



Employee and Family Assistance Program (EFAP) is designed to provide free, confidential support for employees and adult household family members. EFAP offers counseling and other forms of emotional support to help deal with problems that may impact job performance, mental and emotional wellbeing and overall life satisfaction.

PERSONAL

- Mental Health
- Depression and Anxiety Screening
- Substance Use
- Grief and Loss
- Communication
- Anger Management
- Relationships
- Parenting

PROFESSIONAL

- Critical Incidence Response Debriefs
- Leader Consultation and Support
- Return to Work Assistance
- Communication & Conflict Resolution
- Stress Management
- Compassion Fatigue
- Mindfulness

LIFE-WORK RESOURCES

- Financial Concerns
- Elder care Resources
- Child Care Resources
- Veteran Support
- Educational Material
- Linkage to Internal and External Resources
- Tobacco Cessation

ELIGIBILITY

Full-time, part-time and per diem employees, along with their adult household family members, are eligible to meet with a counselor for confidential assessments, short-term counseling, referrals and follow-up services.

LEROYER EMPLOYEE EMERGENCY ASSISTANCE PROGRAM

Assistance is given for financial emergencies which are caused by unexpected events. To be eligible, employees must be actively employed with a minimum of three months of services. This fund is here to help you during these uncertain times. Email efap@uvmhealth.org for an application.

WORKING BRIDGES RESOURCE COORDINATION

Working Bridges, an initiative of the United Way of Northwest Vermont, provides a Resource Coordinator who works with employees seeking connection to community resources to address life issues that may affect work. This assistance helps employees to navigate challenges such as housing, transportation, childcare, budgeting, debt management, legal issues, income supports and more.

Contact Kristin Kany, Resource Coordinator, 802-735-4438 or kristin@unitedwaynwvt.org for an appointment. This service is free and confidential.

Free & Confidential: 7:30am - 5pm, Monday-Friday 802-847-2827 or EFAP@UVMHealth.org

EFAP offers virtual, telephone or in-person appointments. To learn more about EFAP, visit the [EFAP HOME](#) (click the link or go to Intranet Home Page>Employee Resources>Employee & Family Assistance Program).



Voluntary Benefits Accident, Illness, Hospital

Supplemental Medical plans can help you pay for costs you may incur after an accidental injury, illness or hospitalization. These plans are 100% voluntary.

Accident Insurance

Accident insurance pays a lump sum if you become injured because of an accident. It allows you to claim benefits even if the injuries do not keep you out of work. Accident insurance may also complement health insurance if an accident causes you to have medical expenses that your health insurance doesn't cover.

HOW DOES ACCIDENT INSURANCE WORK?

Accident insurance can help pay for a wide range of situations, including initial care, surgery, transportation and lodging and follow-up care. Here's how it works:

- A set amount is payable based on the injury you suffer and the treatment you receive.
- Coverage is available for you, your spouse and eligible dependent children.
- No physical exam required to get basic coverage.
- Accident insurance covers injuries that happen on or off the job.
- Benefit payments are not reduced by any other insurance you may have with other companies.



Critical Illness Insurance

While medical insurance is vital, it doesn't cover everything. If you suffer from a serious illness, such as cancer, stroke or a heart attack, Medical insurance may not provide the coverage you need. Critical Illness insurance will ease the financial strain and help you focus on your recovery.

HOW WILL A CRITICAL ILLNESS CLAIM GET PAID?

After purchasing Critical Illness insurance, if you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum. The payment will go directly to you instead of to a medical provider. The payment you receive can be used for your expenses, such as:

- Child care costs
- Medical expenses
- Travel expenses for you and your family
- Lost wages from missed time at work
- Living expenses

Hospital Indemnity Insurance

Hospital Indemnity insurance is a plan designed to pay costs associated with a hospital admission that may not be covered by other insurance. The plan covers employees who are admitted to a hospital or ICU for a covered sickness or injury. Even if your Medical insurance covers most of your hospitalization, you can still receive payments from your Hospital Indemnity insurance plan to cover extra expenses while you recover.

HOW DOES HOSPITAL INDEMNITY INSURANCE WORK?

You pay monthly premiums for your Hospital Indemnity insurance plan. If you are admitted to the hospital for an injury or illness, your Hospital Indemnity plan makes cash payments to you. And with the payments going directly to you, you can use these emergency funds to pay for costs not covered by your Medical insurance, including medical insurance deductibles, copays and coinsurance, child care expenses while you are in the hospital or cost-of-living expenses as you recover.

Voluntary Benefits ID Protection & Pet Insurance

Allstate Identity Protection

Identity Theft insurance provides credit monitoring and fully managed identity restoration services should you or an immediate family member become a victim of identity theft. This will help you remain productive at home and at work while your identity is restored to pre-theft status. Enroll in [Workday](#) and premiums will be deducted after-tax from your paycheck.

- Check your identity health score
- View and manage alerts in real time
- Monitor your TransUnion credit score and report
- Receive alerts for cash withdrawals, balance transfers and large purchases
- Get reimbursed for fraud-related losses

AllstateSM
IDENTITY PROTECTION



Pet Insurance

My Pet Protection from Nationwide provides coverage for your birds, cats, dogs and exotic pets. Pet insurance helps you provide your pets with the best care possible by reimbursing you for veterinary bills. You can get cash back for accidents, illnesses, hereditary conditions and more.

Pet parents have two levels of reimbursement, 70% or 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 your pet's age or breed, but rather the reimbursement level and the state in which you live.

All employees are eligible to enroll their pets. If you enroll, you will pay Nationwide directly. Premiums are not deducted from your paycheck. Coverage starts 14 days after enrollment. Once your coverage starts, you can visit any veterinarian and submit receipts to Nationwide for reimbursement.

*Pre-existing conditions are not covered and reimbursement options may not be available in all states.





GET A QUOTE & ENROLL

- Online at [UVMHN Pet Insurance Enrollment](#)
- By calling 877-738-7874. Mention you are an employee of UVMHN to receive discounted pricing.

NOTE: If you want to enroll your bird, rabbit, reptile, or other exotic pets you must call to enroll.

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:

[UVMHN Pet Insurance](#)

Enrollment & Premiums:

You can enroll and make changes anytime. Premiums are paid monthly by you.

Helpful Information

- [Learn More About Pet Insurance](#)
- [Pet Insurance Overview](#)
- [FAQ - Pre-enrollment](#)
- [FAQ - Post-Enrollment](#)
- [FAQ - Claim Reimbursement](#)
- [Vitus Vet](#)
- [Vethelpline®](#)



Combined Time Off (CTO)

The Combined Time Off (CTO) Program combines all paid time off into a single program that gives you the flexibility in managing your paid time off.

The amount of CTO employees earn is based on position, length of service and hours worked. CTO provides paid time off for holidays, sick time, vacation and personal days. All regular Full-Time, Part-Time and regularly scheduled (RSS) employees are eligible to accrue CTO. Per diem employees do not accrue CTO.

Eligible employees accrue CTO each pay period on the basis of hours worked and paid time off up to 80 hours. The maximum amount of CTO that can be accrued in an individual's CTO bank is 1 1/2 times the individual's annual accrual, based on authorized hours.

CTO ACCRUAL - ANNUAL FULL-TIME EMPLOYEES*				
NON-EXEMPT POSITIONS				
Years of Employment	CTO Accrual Per Eligible Paid Hour	Hours Accrued Per Year	Days Accrued Per Year**	Maximum Accrual Hours
0-5	0.099726	208	26	312
+5-10	0.118904	248	31	372
10+	0.138084	288	36	432
EXEMPT POSITIONS AND SUPERVISORS				
Years of Employment	CTO Accrual Per Eligible Paid Hour	Hours Accrued Per Year	Days Accrued Per Year**	Maximum Accrual Hours
0-5	0.118904	248	31	372
+5	0.138084	288	36	432
MANAGERS AND DIRECTORS				
Years of Employment	CTO Accrual Per Eligible Paid Hour	Hours Accrued Per Year	Days Accrued Per Year**	Maximum Accrual Hours
Upon Hire	0.138084	288	36	432

* The above CTO accruals are based upon full-time employment working 80 hours per pay period.

** Days per year are expressed as the number of 8-hour CTO days an employee earns over the course of 12 months.

HOLIDAYS

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

HELPFUL INFORMATION

- [CTO Policy](#)
- [CTO Donation Program: Nomination Form](#)
- [CTO Donation Program Policy](#)
- [CTO Program](#)

Flex Time Off (FTO)

Full-time employees who are employed on January 1 will receive FTO.

Less than 10 years of service: 8 hours

More than 10 years of service: 16 hours

When you use FTO as paid time off, you do not accrue CTO for this time. Also, FTO is not 403(b) eligible, which means neither you nor UVMHN make contributions on the FTO earnings.

Employees eligible for FTO can elect to sell this time during Open Enrollment. If you sell FTO, your hourly rate as of January 1 is multiplied by the hours sold. The value is then paid evenly as additional earnings over the course of the calendar year.

PLEASE NOTE

- You must request FTO to be used.
- Any remaining FTO in the last pay period of the year will be forfeited for that year. If you move to a Part-Time or per diem status in the middle of the year, FTO will be forfeited.
- FTO may be used for scheduled time off only. FTO cannot be used for unscheduled time off or low census.
- If you leave employment mid-year, you forfeit any remaining earnings.

CTO Donation Program

If you or your family member experiences an unplanned/unexpected medical emergency or becomes a victim of a major disaster (declared by President of the United States) and as a result exhausts all of your CTO, the CTO Donation Program provides a supportive benefit.

CTO BANK BENEFICIARY OVERVIEW

To be eligible for donation, the recipient's CTO balance cannot exceed their bi-weekly authorized hours. The recipient of a CTO donation may only receive a maximum of 208 donated hours in one calendar year (January-December). Donated hours are available for use by the recipient one pay period after they are deposited into the recipient's CTO bank.

STARTING A CTO DONATION

To establish a CTO Donation Bank the manager or co-worker of the employee experiencing an unexpected hardship, as noted above should send a completed [CTO Donation Program: Nomination Form](#) to the HR Solution Center. An approval/denial of the nomination will be sent to the requesting employee, the employee's manager, and the Human Resources Business Partner.

The donating employee must have a CTO bank balance of at least 40 hours after the transfer of the donation and may only donate in whole hour increments.

Please see [CTO Donation Program Policy](#).



CTO Sell

Any Full-Time or Part-Time employee can sell up to 40 hours of time during Open Enrollment. If you choose to sell time, the hours will be deducted from your CTO bank and then multiplied by your base hourly rate to determine the total value. That value is then paid to the employee in equal amounts throughout the following year's 26 paychecks. The dollars flow into your paycheck as additional income and the taxes are withheld at the supplemental rate.

The only requirement to sell CTO or Cash-in CTO is that you must have at least 40 hours of CTO remaining after the hours have been deducted from your CTO bank.

EXAMPLE

Hourly Rate: \$15

Hours Sold: 40

Calculation: \$15 x 40 hrs / 26 pay periods = \$23.08

Paid Per Paycheck: \$23.08

CTO Cash-In

Cashing in CTO time is another way to convert unused hours into take-home pay. This option provides the employee with a lump sum payment. Any Full-Time, Part-Time, or regularly scheduled employee may cash-in CTO. During Open Enrollment, the employee decides how many hours to cash in (up to their authorized bi-weekly hours) and when in the following calendar year they would like to receive the cash. Taxes are withheld at the supplemental rate.

EXAMPLE

Hourly Rate: \$15.00

Bi-weekly Authorized

Hours: 80 hours

Calculation: \$15 x 80 hrs = \$1,200

You would receive a bonus payment of \$1,200 in the following calendar year based upon when you choose to receive the payment.

Service Credits Allowance

SERVICE CREDIT ALLOWANCES ARE DESIGNED TO REWARD LONG-TERM SERVICE.

Full-Time or Part-Time employees with 10 or more years of service as of December 31 will receive a Service Credit Allowance the following year. The benefit ranges from \$200 to \$500 per year for Full-Time employees and is pro-rated for Part-Time employees.

Service Credit Allowances are paid throughout the year in equal amounts per pay period.

SERVICE CREDITS ALLOWANCE DOLLARS BY PAY PERIOD AND BY YEAR			
Years of Service	Full-Time (72-80 hrs.)	Part-Time (60-71 hrs.)	Part-Time (40-59 hrs.)
10-14	\$7.70 - (\$200/yr.)	\$5.77 - (\$150/yr.)	\$3.85 - (\$100/yr.)
15-19	\$11.54 - (\$300/yr.)	\$8.65 - (\$225/yr.)	\$5.77 - (\$150/yr.)
20-24	\$15.39 - (\$400/yr.)	\$11.54 - (\$300/yr.)	\$7.70 - (\$200/yr.)
25+	\$19.23 - (\$500/yr.)	\$14.43 - (\$375/yr.)	\$9.62 - (\$250/yr.)

Tuition & Certification Reimbursement

UVMHN is dedicated to supporting your professional growth through higher education. We provide tuition and certification reimbursement to help you to meet your goals.

Tuition Assistance

ALWAYS IMPROVING

Upon your 1-year anniversary of full-time employment at UVMHN, you become eligible to use an annual allotment of \$3,200 to pursue your education. After five years, this amount increases to \$5,000. You can pursue a degree, pay for graduate programs, or continue with lifelong learning opportunities. Part-time employees are also eligible for this program, prorated to their time at work after their first anniversary.

Certification Reimbursement

CREDENTIALS THAT COUNT

After 6-months of employment, you can apply for a grant of \$500 to offset the cost of advanced personal certification in your field. This program was established to support your career development as professional certifications are an important part of what you do. This grant is available once per year.

Tuition & Certification Reimbursement

It's easy! You just submit the reimbursement request once for the tuition and certification process. You also have access to the Budget Dashboard where you can see how much money you have available for the current fiscal year.

Employee Discounts

All employees who have a UVMHN/UVMHC ID badge (white background) are eligible for discounts at certain companies. Employees must show their ID badge to receive the discount.

Discounts Include

- Automotive
- Banking
- Electronics
- Entertainment
- Food & Lodging
- Physical Activity & Wellness
- Retail Services
- Seasonal Discounts

VENDOR LIST & DISCOUNTS

Save with UVMHN [Employee Discounts](#).

Discount information provided is for convenience and informational purposes only. UVMHN does not endorse any of the vendors or products included with the discount program.



Leaves of Absence

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 UVMHC or an UVMHN affiliate for at least 12 months at the start of the leave
- Worked 1,250 hours 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.

If the leave is taken as a continuous 12-week leave period, you may be eligible for an additional four (4) weeks of Supplemental Leave. With manager's approval, you may work a reduced schedule during the Supplemental Leave period.

To initiate a claim, notify your manager of your need for time away and contact The Hartford. Information can also be found at the following website: [TheHartfordMyBenefits](#). Return the **Request for Time Away from Work** form located in the **STD Guidebook** on page 6 to the HR Solution Center via fax at 802-847-2573, email at LOA@UVMHealth.org or call 844-777-0886. Indicate whether you would like to use CTO while on FML.

Bonding Leave

Bonding Leave 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 child or placement of a child 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, spouse, or parent of the employee's spouse.

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:

1. Understand what benefits are available to you
2. Notify your manager of your need for leave with as much advance notice as possible
3. Call The Hartford to initiate a Leave
4. Complete the **CTO Use During Leave** form



Accommodation Under the Americans With Disabilities Act Amendments Act (ADAAA)

UVMHN/UVMMC provides reasonable accommodation for a known physical or mental limitation of an otherwise qualified employee or applicant that enables 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 available. To apply, notify your manager and contact The Hartford. The Hartford will provide an ADAAA Medical Assessment Form that you are required to have completed by your medical provider regarding your accommodation.

Workers' Compensation

If you become **ill or injured as related to or caused by your work**, you may be eligible for Workers' Compensation in accordance with Vermont Workers' Compensation Law. The University of Vermont Health Network partners with CCMSI as our third party administrator for processing and making Worker's Compensation claim determinations.

TO ENSURE YOUR **INJURY/ILLNESS** IS CONSIDERED, PLEASE FOLLOW ALL OF THE FOLLOWING STEPS

1. DOCUMENT THE EVENT

- For most injuries, illnesses and events, complete the **Report of Event (ROE)** form alternatively, complete the SHARP or SAFE report if appropriate.

2. IF YOU REQUIRE MEDICAL TREATMENT

- To expedite your workers' compensation claim: If it is during regular business hours and not life threatening, visit **Concentra** – our partnering Occupational Health provider – and notify them you are a UVMHN employee. **Concentra** is located at:

57 Fayette Drive
Unit 1
South Burlington VT
802-658-5756

- Sign the VT Form 7 Medical Authorization provided to you, which is required in order for CCMSI to process your claim.
- For life threatening and/or otherwise serious injuries, call 911 or proceed to the nearest emergency room.

3. IF YOU WILL - OR HAVE ALREADY - MISSED TIME AT WORK AS A RESULT OF YOUR INJURY OR ILLNESS

- Indicate that you will be missing time in your ROE
- Update your supervisor as soon as possible regarding any work status changes
- Update the HR Solution Center ASAP by emailing **LOA@UVMHealth.org** with a list of your absences
- If you already have an open claim, update your CCMSI adjuster of any new missed time
- In order to return to work in any capacity while having a workers' compensation claim, the injured employee must be cleared to work by a qualified health provider.

If your claim is determined to be work related and you are out of work for more than 3 days CCMSI will call you. You can also contact CCMSI at 800-985-2583.

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.

Leave of Absence for Military Service

UVMHN/UVMHC values the experience and knowledge of those who have performed, currently perform or will perform military service. As such, we seek to employ current citizen soldiers and other veterans from the community. The UVM Medical Center will not discriminate or retaliate against a current or prospective employee concerning initial employment, available benefits, training, promotion, employment opportunities or any other term, condition or benefit of employment based upon past, current or future military service.



ELIGIBILITY

A regular, non-temporary employee who leaves employment to perform voluntary or involuntary service in the uniformed services will be entitled to reemployment, provided they meet the USERRA eligibility criteria. The employee's cumulative period or periods of military service, relating to employment with the UVM Medical Center, shall not have exceeded five years (the "five-year rule").

An employee who is away from work performing military service will receive benefits during the military related absence, comparable to the benefits offered to employees on other forms of leave, paid or unpaid.

- For 30 days or less, health insurance benefits will continue as if the employee were continuously employed.
- For 31 or more days the employee may elect to continue health coverage with the UVM Medical Center for a period of up to two years - the employee will be required to pay 102% of the premium.

An employee returning from service and who meets the USERRA eligibility criteria is entitled to immediate reinstatement to the UVM Medical Center's health, dental, and life insurance coverage upon reemployment. An employee's CTO bank and Extended Sick Bank will be maintained during the leave of absence.

PAY DIFFERENTIAL

An employee who is called to military service and whose normal weekly pay exceeds the service pay will be offered a pay differential. Eligible employees are required to submit a copy of their military leave earnings statement for the covered period.

An employee who requests a military leave in excess of two weeks should notify their manager and contact The Hartford.

REEMPLOYMENT

To have reemployment rights with the UVMHN, returning employee must have completed the period of military service without having received anything other than an honorable discharge or, in certain circumstances, having been dismissed or dropped from the rolls of the uniformed service. In addition the employee must not have exceeded the "five-year rule" of non-exempt military service. For periods of service of 31 days or more the UVMHN may ask returning employees to submit documentation demonstrating that their (1) application for re-employment is timely, (2) return is within the 5 year service limitation, and (3) separation from service was other than non-disqualifying.

Returning employees must make timely application for reemployment or have been timely in reporting back to work. For a complete schedule please see the policy.

Other Leaves of Absence

UVMHN/UVMMC offers a variety of other leaves, both paid and unpaid.

- **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 the immediate family: spouse; parent; step-parent; child; step-child; sibling; step-sibling; grandparent; grandchild; mother-in-law; father-in-law; son-in-law; daughter-in-law; sister-in-law; or brother-in-law. Requests for exceptions for other close family or household members may be granted at the discretion of the manager.

- **Personal Leave of Absence**

Up to six (6) months of unpaid leave may be granted to an employee with one (1) year of service in the event of unusual circumstances and personal emergencies. CTO must be exhausted in order for leave to be granted.

- **Volunteering**

An employee who has completed one (1) year of service may request a leave of absence, up to 10 consecutive scheduled worked days per calendar year, to volunteer in support of any charitable organization as defined in Section 501 (c)(3) of the IRS Code. Time must be taken in full day increments and can be unpaid or the employee may use CTO.

- **Educational Leave of Absence**

Unpaid leave of absence for up to 24 months may be granted to an employee who has completed one (1) year of service to pursue educational opportunities that promote their growth and development at UVMHN.

- **Jury Duty**

Time will be excused from work with pay for the time required performing jury duty.

- **Election to the State Legislature**

Any employee who, in order to serve as a member of the Vermont General Assembly, must leave a full time or part time position will be granted an unpaid leave of absence to perform any official duty in connection with their elected office.

- **Health Service**

An unpaid leave of absence for up to twelve (12) months may be granted to an employee with one year of service to participate in health services for the benefit of underdeveloped areas or disadvantaged people. Only one leave of up to twelve (12) months is permitted every three years.

- **Professional Work Experience/Expertise**

An unpaid leave of absence of up to twelve (12) months may be granted to an employee with five (5) or more years of consecutive Full-Time or Part-Time service, upon proof of employment in a health care related position to gain additional professional expertise. Only one leave of up to twelve (12) months is permitted every five (5) years.

To initiate a leave of absence notify your manager and contact the HR Solution Center to discuss your eligibility by calling 844-777-0886 or by emailing LOA@UVMHealth.org.

If the employee is unable to return to work within the approved leave time, they must request an extension in writing to the Vice President of Human Resources. Each request will be considered on an individual basis. Employees not returning within the approved leave time will be considered as having voluntarily terminated their employment with the UVMHN. Any pay raises or other changes to pay will take effect when the employee has returned to work at the full pre-leave of absence capacity and will not be retroactive.



Appendix – Life Insurance & Voluntary Rates

LIFE INSURANCE

ADDITIONAL LIFE INSURANCE RATES		
Bi-weekly Rates are per \$1,000 of Coverage	Employee	Spouse
	Term Life with AD&D	Term Life
Age 29 and Under	\$0.026	\$0.0403
30-34	\$0.034	\$0.0518
35-39	\$0.039	\$0.0576
40-44	\$0.046	\$0.0691
45-49	\$0.069	\$0.1037
50-54	\$0.121	\$0.1786
55-59	\$0.199	\$0.2938
60-64	\$0.340	\$0.5011
65-69	\$0.661	\$0.9730
70-74	\$1.263	\$1.8600
Age 75 and Over	\$2.060	\$3.3400
Child Term Life	\$0.284	

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
 $\$100,000 / \$1,000 = \$100 \times \$0.039 = \$3.90$
 Bi-weekly premium for \$100,000 of coverage will be \$3.90 or \$93.60 annually
 You are electing \$50,000 of spouse life insurance and they are 43 years old
 $\$50,000 / \$1,000 = \$50 \times \$0.0518 = \$2.59$
 Bi-weekly premium for \$50,000 of coverage will be \$2.59 or \$62.16 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) $\$14,000 / \$1,000 = \$14 \times \$0.069 = \$0.97$ You would have \$0.97 of additional taxable income each pay period or \$25.22 annually.	BI-WEEKLY IMPUTED INCOME RATE PER \$1,000 OF BENEFIT	
		Age 24 and Under
	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

2023 UVMHN HSA CONTRIBUTIONS

2023 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.

CALCULATING ADDITIONAL LONG-TERM DISABILITY PREMIUMS	BI-WEEKLY RATE PER \$100 OF COVERAGE	
	<p>A 46 year old employee has a salary of \$2,500 per month (\$30,000/year). The basic LTD benefit of 60% would be \$1,500/month (\$18,000/year).</p> <p>If the employee buys the Additional LTD coverage, the benefit would be 66.67%, or \$1,650 per month (\$19,800/year).</p> <p>The cost of the 66.67% Additional LTD coverage would be \$1.62 per pay period (\$2,500 salary per month / 100 x \$0.0646 = \$1.62).</p>	Age 24 and under
Age 25-29		\$0.0217
Age 30-34		\$0.0254
Age 35-39		\$0.0323
Age 40-44		\$0.0434
Age 45-49		\$0.0646
Age 50-54		\$0.0826
Age 55-59		\$0.0969
Age 60-64		\$0.1112
Age 65-69		\$0.1075
Age 70-74	\$0.1075	
Age 75 and over	\$0.1075	



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 ILLNESS - 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 ILLNESS - 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

TUITION AND CERTIFICATION ELIGIBILITY

TUITION		
Non-Union Eligible at 1 year	Nursing-Union Eligible at 1 year	Technical/Professional Union Eligible at 6 months
Full-Time		
Less than 5 years of employment = \$3,200 More than 5 years of employment = \$5,000		
Part-Time		
Less than 5 years of employment Authorized hours % x \$3,200 = Tuition Eligibility	Less than 5 years of employment Hours Worked over the last 12 months % x \$3,200 = Eligibility	
More than 5 years of employment Authorized hours % x \$5,000 = Tuition Eligibility	More than 5 years of employment Hours Worked over the last 12 months % x \$5,000 = Eligibility	
Per diem bargaining unit nursing staff are eligible for pro-rated tuition reimbursement.		
CERTIFICATION		
Non-Union Eligible at 6 months	Nursing-Union Eligible at 6 months	Technical/Professional Union Eligible at 6 months
Full-Time & Part-Time		
\$500	\$750	\$500
Per Diem		
Hours Worked over the last 12 months % x \$500 = Total Eligibility	Hours Worked over the last 12 months % x \$750 = Total Eligibility	Hours Worked over the last 12 months % x \$500 = Total Eligibility

Common Health Insurance Terms

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 uses 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/COPAY

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 copay 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 copays. 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).

Legal Notices

NOTICE OF HIPAA SPECIAL ENROLLMENT RIGHTS

Our records show that you may be eligible to participate in the medical insurance offered under The University of Vermont Medical Center Employee Welfare Benefits Plan (the “Plan”).

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 30 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 30 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 Human Resources at (518) 562-7300.

LIFETIME AND ANNUAL LIMITS

The Plan does not impose a lifetime limit on essential health benefits. Effective for Plan Years beginning after December 31, 2013, the Plan does not impose any annual limits on essential health benefits. Essential health benefits are defined in guidance and regulations issued by the Department of Health and Human Services.

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 copayment, 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. For the plan year beginning January 1, 2023, the list was updated to include, for example, special preventive services for women, such as double electric breast pumps, and counseling to prevent and reduce obesity in midlife women (ages 40 to 60). Universal screening for suicide risk for individuals ages 12 to 21, behavioral, social and emotional screening for children and risks assessment for cardiac arrest or death for individuals ages 11 to 21 and risk assessment for hepatitis B virus infection in newborn to 21 year-olds are another example of expanded services. For more information about covered preventive services, visit Blue Cross and Blue Shield website at:

<https://member.myhealthtoolkitvt.com/web/public/brands/vt/live-healthy/preventive-care/>

For prescription drugs included in preventive services required by the Affordable Care Act, visit NAVITUS website at: www.Navitus.com

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 Human Resources at (518) 562-7300 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, Monday – Friday, 8:30 a.m. to 8:00 p.m., or visit myhealthtoolkitvt.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).

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit your question or a complaint.

Visit <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal law.

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 began on March 18, 2020 and will end when the COVID-19 public health emergency is no longer in effect (currently expected to end in October 2022). 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. In addition, beginning on January 15, 2022, the Plan will cover without cost sharing or physician's order or supervision at-home diagnostic COVID-19 tests approved by the ADA while the public health emergency is in effect. When you obtain these tests through a participating pharmacy or directly from NAVITUS online by visiting www.navitus.com/members, the Plan will cover the entire cost of the tests, up to 8 tests per enrolled individual per a 30-day period. If you obtain a test from a non-participating pharmacy, the Plan's reimbursement will be limited to \$12 dollar per test (or, if lesser, the actual cost of the test), up to the 8 tests/30 days. For more information, visit www.navitus.com.

PRICE TRANSPARENCY

Beginning on July 1, 2022, group health plans are required to make publicly available machine-readable files containing information about the rates the plan negotiated with its network providers, and allowed amounts and billed charges by out-of-network providers for specific medical items and services. This information is updated monthly but for out-of-network providers would reflect historic prices for the 90-day period that begins 180 days before the information is published. You may access this information at <https://hrportal.ehr.com/uvmhn/Home/Tools-Resources/Legal-Notices#caaandransparencyincoverage>.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that medical information about you and your health is personal and should be kept private. Moreover, federal law imposes requirements on the group health programs offered under the The University of Vermont Medical Center Employee Welfare Benefits Plan (the "Plan") to ensure the privacy of your personally identifiable health information. This Notice is intended to summarize these rules and to inform you about:

- the Plan's uses and disclosures of Protected Health Information ("PHI") (as defined below);

- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services (the "Secretary"); and,
- who (the person or office) to contact for further information about the Plan's privacy practices.

This Notice applies to the medical, dental, and employee assistance programs, as well as the health care flexible spending accounts under the Plan. The University of Vermont Health Network ("UVMHN" or "Plan Sponsor") hereby designates programs as an Affiliated Covered Entity (within the meaning of 45 C.F.R. § 164.105(b)) and an Organized Healthcare Arrangement (within the meaning of 45 C.F.R. § 160.103). These components of the Plan may share an individual's PHI with one another, subject to the requirements set forth in the HIPAA rules (See e.g., 45 C.F.R. §§ 164.105, 164.506, and 164.520).

Generally, the term "Protected Health Information" ("PHI") includes all individually identifiable health information concerning you that is maintained by the Plan. PHI does not include health information that is held by UVMHN in its role as your employer (for example health information held for purposes of your employment records). "Unsecured PHI" is PHI that is not secured through the use of a technology or methodology that renders the PHI unusable, unreadable, or indecipherable.

PHI uses and disclosures by the Plan are regulated by a federal law called the Health Insurance Portability and Accountability Act of 1996 (referred to as "HIPAA") and the regulations that enforce HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"). You may find these regulations at 45 Code of Federal Regulations Parts 160 and 164.

Where group health plan benefits are provided through certificates of insurance, or as part of an organized health care arrangement that includes benefits provided under a certificate of insurance, the notice of privacy practices is provided directly by the applicable insurance company. For group health plan benefits provided through certificates of insurance, you will also receive notices of privacy practices from the applicable insurance company regarding their practices. This Notice describes the Plan's practices with respect to any PHI that it handles directly or with respect to self-insured benefits.

NOTICE OF PHI USES AND DISCLOSURES

GENERAL RULE

Generally, except for the purposes discussed below, the Plan cannot use or disclose your PHI without your written authorization. Moreover, if you provide authorization to use or disclose your PHI, you have the right to revoke your authorization at any time, except to the extent that the Plan has already relied upon it. To revoke a written authorization, please write to the Plan's Privacy Officer.

USES AND DISCLOSURES OF PHI TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The Plan and individuals or entities who the Plan has engaged to assist in its administration (called “business associates”) will use PHI to carry out “treatment,” “payment” and “health care operations” (these terms are described below). Neither the Plan, nor the business associates, need your consent or authorization to use or disclose your PHI to carry out these functions.

1. “Treatment” includes the provision, coordination or management of health care and related services. This includes consultations and referrals between one or more of your health care providers, and the coordination or management of health care by a health care provider with a third party. For example, the Plan can disclose and discuss with your doctor or pharmacist other medications you may be receiving to reduce the chances that your taking a particular medication will result in unintended side effects.
2. “Payment” includes actions to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate coverage. Payment activities include billing, claims processing, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review, and pre-authorizations. For example, the Plan can discuss your PHI with your doctor to make sure your claims are properly paid.
3. “Health Care Operations” include quality assessment and improvement, underwriting, premium rating, stop-loss (or excess-loss) coverage claims submissions, creation or renewal of insurance contracts, and other activities relating to Plan coverage. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions (including fraud and abuse compliance programs), business planning and development, business management, and general administrative activities. For example, the Plan may submit your health information to external auditors or agencies to assess the quality of a health plan. The Plan may also submit your health information to a stop-loss insurance carrier or to obtain pricing information.

Business associates provide business services to the Plan related to transactions with you like plan administration, claim processing, or audit services. Examples of third parties include third party administrators, consultants and health advocacy companies. The Plan requires business associates to agree, in writing, to maintain the confidentiality of the health information to which they are provided access and to notify us if there is a probable compromise of your Unsecured PHI. If a business associate discloses your health information to a subcontractor or vendor, the business associate will have a written contract to ensure that the subcontractor or vendor also protects the privacy of the information.

The Plan also may disclose PHI to employees of UVMHN if such employees assist in carrying out treatment, payment and health care operations, provided that the PHI is used for such purposes. These individuals receive training to ensure that they will protect the privacy of your health information and that it is used only as described in this notice or as permitted by law. Health information will generally not be disclosed to UVMHN in its capacity as Plan Sponsor as participating employer in the Plan, except that information regarding enrollment in the Plan or enrollment in a specific benefit will be disclosed to allow for payroll processing of premium payments. Summary health information may be provided to the Plan Sponsor, which may be used to shop for insurance or amend the Plan, but identifying information, such as your name or social security number, will not be included. Nonetheless, the Plan cannot use or disclose genetic information for underwriting purposes. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other UVMHN employee or department, and (2) will not be used by UVMHN for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by UVMHN.

Most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require your written authorization. The Plan will not disclose any of your health information for marketing purposes if the Plan will receive direct or indirect financial remuneration not reasonably related to the Plan’s cost of making the communication. The Plan will not sell your PHI to third parties. The sale of PHI, however, does not include a disclosure for public health purposes, for research purposes where the Plan will only receive remuneration for its costs to prepare and transmit the health information, for treatment and payment purposes, for sale, transfer, merger or consolidation of all or part of the Plan, for a business associate or its subcontractor to perform health care functions on the Plan’s behalf, or for other purposes as required and permitted by law.

Uses and disclosures not described in this Notice will be made only with your written authorization unless specifically authorized by the HIPAA rules.

USES AND DISCLOSURES OF PHI FOR WHICH CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT IS NOT REQUIRED

HIPAA sets forth a limited number of additional situations in which the Plan may use or disclose your PHI without your authorization, including:

- When such uses or disclosures are required by law.
- When uses or disclosures are permitted for purposes of public health activities, including preventing or controlling disease, injury or disability, and when necessary to report product defects in connection with FDA regulated products, to permit product recalls with respect to such products, and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- When the Plan is authorized by law to allow reporting of information about abuse, neglect or domestic violence to public authorities, and there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such cases, the Plan will promptly inform you that such a disclosure has been or will be made unless the notice would cause you a risk of serious harm. In instances of reports of child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- When required by judicial or administrative order, or in response to a subpoena, discovery request or other lawful process which is not accompanied by an order, provided that certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that (1) the requesting party has made a good faith attempt to provide written notice to you, or (2) the party seeking the information has made reasonable efforts to secure a qualified protective order.
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, for disclosing information about you if you are suspected of being a victim of a crime, but only if you agree to the disclosure or the Plan is unable to obtain your agreement because of incapacity or emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against you, that the immediate law enforcement activity would be materially and adversely affected by waiting to obtain your agreement, and that disclosure is in your best interest as determined by the exercise of the Plan's best judgment.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out funeral directors' duties with respect to the decedent.
- We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- For cadaveric organ, eye or tissue donation purposes, to organ procurement or like entities.
- If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- For research, when: (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.
- When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably believed to be able to prevent or lessen the threat, including the target of the threat.
- If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

- If you do not object, you are not present, or your consent cannot be obtained because of your incapacity or an emergency circumstance, the Plan may, in the exercise of its professional judgment, disclose to your family member, relative, or other person who is responsible for your care, or for the payment of your care, your PHI directly relevant to such care or payment, if the Plan concludes that disclosure is in your best interests, including following your death.
- For fundraising purposes, if the information used or disclosed is demographic information, including name, address, or other contact information, age, gender, and date of birth, dates of health service information, department of service information, treating physician, outcome information, and/or health insurance status. Each fundraising communication made to you will provide you with an opportunity to opt-out of receiving any further fundraising communications. The Plan will also provide you with an opportunity to opt back in to receive such communications if you should choose to do so.
- For those specialized government functions set forth in the regulations promulgated pursuant to HIPAA or such other purposes provided under HIPAA.

WE ARE REQUIRED TO DISCLOSE YOUR PHI TO THE SECRETARY WHEN THE SECRETARY IS INVESTIGATING OR DETERMINING OUR COMPLIANCE WITH THE HIPAA PRIVACY RULE.

YOUR RIGHTS AS INDIVIDUALS

Right to Request Restrictions on Uses and Disclosures of PHI

If you wish, you may (1) request that the Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or (2) request that the Plan restrict uses and disclosures of your PHI to family members, relatives, friends or other persons identified by you who are involved in your care or the payment for your care. Please note, however, that the Plan is not required to agree to your request. You have the right to request that your provider not disclose health information to the Plan if you have paid for a service in-full, and the disclosure is not otherwise required by law. The request for restriction to the Plan will only be applicable to that particular service. You will have to request a restriction for each service thereafter from your provider.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations to better ensure your privacy.

Requests for restrictions and to receive communications by alternative means or at alternative locations should be made to the following:

UVM Health Network
95 St. Paul Street
Suite 220
Burlington VT 05401

Right to Inspect and Copy PHI

You also have a right to inspect and obtain paper or electronic copies of your PHI to the extent that it is contained in a “designated record set.” If you would like an electronic copy of your health information maintained by the Plan, it will provide you a copy in the electronic form and format as requested as long as it can readily be produced in such form and format. Otherwise, the Plan will cooperate with you to provide a readable electronic form and format as agreed. This right extends for as long as the Plan maintains the PHI, but does not apply to: psychotherapy notes; information compiled in anticipation of, or for use in, a civil, criminal or administrative action or proceeding; or information subject to the Clinical Laboratory Improvement Amendments of 1988 (to the extent that providing access to that information would be prohibited by law), and information which is exempt from those Amendments. If the Plan denies your request to inspect and copy your PHI, we will provide such denial in writing. Generally, if you are denied access to health information, you may request a review of the denial in accordance with the instructions in the denial letter.

A “designated record set” includes: medical records and billing records about individuals which are maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; and other information used by or for a covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not considered part of a designated record set.

The requested information will be provided within 30 days if the information is maintained on site, or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following:

UVM Health Network
95 St. Paul Street
Suite 220
Burlington VT 05401

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise review rights with respect to the denial, and a description of how you may complain to the Secretary.

Right to Amend PHI

You have the right to request that the Plan amend your PHI or a record about you in a designated record set that is inaccurate or incomplete for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosure of your PHI.

Requests for amendment of PHI in a designated record set should be made in written form, including a statement explaining the reason for the amendment, to the following:

UVM Health Network
95 St. Paul Street
Suite 220
Burlington VT 05401

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures
At your request, the Plan will also provide you with an accounting of disclosures of your PHI by the Plan and/or the Plan's business associates during the period covered by your request (which may be a period of up to six years prior to the date of your request for paper records or three years prior to the date of your request for "Electronic Health Records," as defined in HITECH). Unless required by law, the accounting will not include disclosures:

- for purposes of treatment, payment, or health care operations (except in the case of disclosures that involve "Electronic Health Records," as defined in HITECH);
- made to you;
- made pursuant to your authorization;
- made to friends or family in your presence or because of an emergency;
- made for national security purposes;
- incidental to a use or disclosure otherwise permitted or required by law;
- as part of a limited data set; and
- incidental to otherwise permissible disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive Notification in the Event of a Breach

You have the right to be notified if there is a probable

compromise of your Unsecured PHI within sixty (60) days of the discovery of the breach. The notice will include:

- a brief description of what happened, including the date of the breach and the discovery of the breach;
- a description of the type of Unsecured PHI that was involved in the breach;
- any steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of the investigation into the breach, mitigation of harm to you and protection against further breaches; and
- contact procedures to answer your questions.

Personal Representatives

An individual may exercise his/her rights under this Notice through a personal representative. If you have a personal representative, he/she will, unless otherwise allowed by law, be required to produce evidence of his/her authority to act on your behalf before he/she will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as your conservator or guardian; or
- proof that the representative is your parent (if you are a minor child).

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to you if it is believed that you may be subject to abuse or neglect. This also applies to personal representatives of minors.

Copies of this Notice

You have a right to obtain a paper copy of this Notice from the Plan upon request. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

To obtain a paper copy of this Notice, contact:

UVM Health Network - UVMHN
Privacy Officer
95 St. Paul Street
Suite 220
Burlington VT 05401
802-847-2667

THE PLAN'S DUTIES

Federal law requires the Plan to maintain the privacy of PHI in accordance with HIPAA and provide individuals (employees and their dependents enrolled in the Plan) with notice of the Plan's legal duties and privacy practices. The Plan is required to abide by the terms of the privacy notice then in effect. The Plan reserves the right to change their privacy practices and to apply the changes to any PHI received or maintained by the Plan. If a privacy practice is materially changed, a revised version of this Notice will be provided to all current Plan participants.

In the event of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice, a revised version of this Notice will be posted to the Plan's website by the effective date of the material change, and a hard copy of the revised Notice (or information about the material change and how to obtain the revised Notice) will be provided in the Plan's next annual mailing. Alternatively, a revised copy may be distributed within 60 days of the effective date of any material change, and the revised Notice will also be available on the Plan's website.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. Where practicable, the Plan will limit uses or disclosures to a limited data set.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment purposes;
- uses or disclosures made to you;
- uses or disclosures authorized by you;
- disclosures made to the Secretary;
- uses or disclosures that are required by law; and
- uses or disclosures that are required by the Plan's compliance with legal requirements.

De-Identified Information, Limited Data Sets, and Summary Information

This Notice does not apply to health information that has been de-identified. De-identified information is information that does not identify an individual (i.e., you) and with respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Plan may use or disclose information in a limited data set, provided that the Plan enters into a data use agreement with the limited data set recipient that complies with the federal privacy regulations. A limited data set is PHI which excludes certain direct identifiers relating to you and your relatives, employers and household members.

The Plan may disclose "summary health information" to the Plan Sponsor or UVMHN without your authorization if the Plan Sponsor or UVMHN requests the summary information for the purpose of obtaining premium bids from health Plan for providing health insurance coverage under the Plan, or for modifying, amending or terminating the Plan. "Summary health information" means information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom UVMHN has provided health benefits under the Plan, and from which most identifying information has been deleted. The Plan may also disclose to UVMHN information on whether an individual is participating in the Plan and the coverage in which an individual has enrolled.

YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR THE SECRETARY

If you believe that your privacy rights have been violated, you may complain to the Plan by contacting the following individual, at the following street address, telephone number and e mail address:

UVM Health Network
95 St. Paul Street
Suite 220
Burlington VT 05401
802-847-2667

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

WHO TO CONTACT AT THE PLAN FOR MORE INFORMATION

If you have any questions regarding this Notice or the subjects addressed in the Notice, you may contact the Privacy Officer at the following street address, telephone number and e-mail address:

UVM Health Network
Privacy Officer
95 St. Paul Street
Suite 220
Burlington VT 05401
802-847-2667

This Notice represents the Plan's efforts to summarize the privacy regulations under HIPAA. In the event of a discrepancy between the terms or requirements of this Notice and the privacy regulations themselves, the terms of the regulations shall prevail.

The date of this Notice is October 1, 2022.

IMPORTANT NOTICE FROM UVMHN ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the health plan provided by UVMHN (the plan) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage under the UVMHN Plan, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage under the UVMHN Plan and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. UVMHN has determined that the prescription drug coverage offered by the UVMHN Plans administered by Empire HealthChoice Assurance, Inc. and BlueCross BlueShield are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current UVMHN Plan coverage will not be affected, but the plan will coordinate its coverage with the Medicare prescription drug plan as described below. In general, the UVMHN Plan coverage will become secondary to the Medicare Part D coverage (and Medicare will pay primary) if the UVMHN Plan coverage is no longer provided in connection with an employee's or spouse's active employment status (for example, if the eligible employee is retired, if the eligible employee terminates employment with a participating employer and elects COBRA continuation coverage, if the eligible employee is absent from work with a participating employer due to disability in excess of six months, or if the eligible employee or dependent have been receiving Medicare due to End Stage Renal Disease in excess of 30 months).

Your current coverage under the UVMHN Plan is as follows:

1. If you have a prescription filled with a Tier One Drug, you must pay the pharmacy either a \$5 Copayment or the cost of the Tier One Drug, whichever is less, for each separate prescription or refill for that Tier One Drug. The pharmacy will be paid directly by the UVMHN Plan for the remainder of the cost of the prescription or refill. The Copayment for Tier One Drugs does not apply to covered dependent children under age 19.
2. If you have a prescription filled with a Tier Two Drug, you must pay the pharmacy either a \$35 Copayment or the cost of the Tier Two Drug, whichever is less, for each separate prescription or refill for that Tier Two Drug. The pharmacy will be paid directly by the UVMHN Plan for the remainder of the cost of the prescription or the refill.
3. If you have a prescription filled with a Tier Three Drug, you must pay the pharmacy either a \$70 Copayment or the cost of the Tier Three Drug, whichever is less, for each separate prescription or refill for that Tier Three Drug. The pharmacy will be paid directly by the UVMHN Plan for the remainder of the cost of the prescription or refill.

For purposes of determining the amount you must pay under Subparagraphs (1) through (3) above, the term "cost" means the rate of payment agreed to between the Participating Pharmacy and the UVMHN Plan for a Prescription Drug or the Participating Pharmacy's actual charge for the Prescription Drug, whichever is less.

NOTE: The UVMHN Plan will NOT pay for any benefits for drugs that you purchase at a Non-Participating Pharmacy.

Please refer to your Empire or BlueCross BlueShield benefit booklet for additional details, including descriptions of the underlined terms above. This notice is not a governing Plan document, and in the event of any inconsistency, the official Plan document (including the Empire benefit booklet) will govern.

If you do decide to join a Medicare drug plan and drop your current UVMHN Plan coverage, be aware that you and your dependents may not be able to get this coverage back until the beginning of the next plan year. In that case, you may rejoin the UVMHN Plan during the open enrollment period held each fall for coverage effective the following January 1st. In addition, you may also be eligible to make changes or enroll in the UVMHN Plan throughout the year, if you have a qualifying status change event.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage under the UVMHN Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

MEDICAL PLAN	UVMHN 250 & 400 Plan		UVMHN 1500 & 3000 HDHP with HSA	
Preventive Drugs	Covered as a copay based on formulary tier.		Certain Preventive Drugs are covered as a copay based on formulary tier.	
Pharmacy	Network Pharmacy		Copays 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	\$150	\$50	\$150
Non-Participating Pharmacy				
All Tiers	Covered at 50%		Not Covered	

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

IS THE UVMHN HEALTH CARE PLAN COVERAGE ALSO CREDITABLE COVERAGE FOR PURPOSES OF MEDICARE PART B?

Not necessarily. This notice only addresses whether the UVMHN Plan's coverage is creditable for purposes of Medicare Part D. Similar concepts apply, however, for Medicare Part B.

For example, if you do not enroll for Medicare Part B at your earliest opportunity, then you will need to wait until the next annual enrollment period before you will have another opportunity to enroll for coverage, and when you do enroll you will have to pay a premium penalty, unless you have had creditable coverage in the interim. For purposes of Medicare Part B, creditable coverage means:

- employer group health plan coverage that is provided to you in connection with your own current employment status; or
- employer group health plan coverage that is provided to you in connection with your spouse's current employment status.

Coverage is considered to be in connection with an employee's current employment status if the eligible employee is actively working. Coverage is not in connection with an employee's current employment status if the eligible employee is retired, if the eligible employee terminates employment and elect COBRA continuation coverage, if the eligible employee is absent from work due to disability in excess of six months, or for employees who have been receiving Medicare due to End Stage Renal Disease in excess of 30 months.

Contact Medicare at the number(s) below for more information about Medicare Part B special enrollment periods and premium penalties.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if Plan coverage changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 10/1/2022

Contact: Benefits, Human Resources
UVM Health Network
1 South Prospect St
Burlington VT 05401
844-777-0886

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility -

ALABAMA - MEDICAID

Website: <http://www.myalhipp.com/>
Phone: 1-855-692-5447

ALASKA - MEDICAID

The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS - MEDICAID

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - MEDICAID

Website: Health Insurance Premium Payment (HIPP) Program
<http://dhcs.ca.gov/hipp>
Phone: 916-445-8322 Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO - HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): <https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>
HIBI Customer Service: 1-855-692-6442

FLORIDA - MEDICAID

Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA - MEDICAID

A HIPP Website: <https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: (678) 564-1162, Press 2

INDIANA - MEDICAID

Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/>
Phone: 1-877-438-4479
All other Medicaid
Website: <https://www.in.gov/medicaid/>
Phone 1-800-457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website: <https://dhs.iowa.gov/ime/members>
 Medicaid Phone: 1-800-338-8366
 Hawki Website: <http://dhs.iowa.gov/Hawki>
 Hawki Phone: 1-800-257-8563
 HIPP Website:
<https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
 HIPP
 Phone: 1-888-346-9562

KANSAS – MEDICAID

Website: <https://www.kancare.ks.gov/>
 Phone: 1-800-792-4884

KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx> Phone: 1-855-459-6328
 Email: KIHIPP.PROGRAM@ky.gov
 KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>
 Phone: 1-877-524-4718
 Kentucky Medicaid Website: <https://chfs.ky.gov>

LOUISIANA – MEDICAID

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
 Phone: 1-888-342-6207 (Medicaid hotline) or
 1-855-618-5488 (LaHIPP)

MAINE – MEDICAID

Enrollment Website: <https://www.maine.gov/dhhs/ofi/applications-forms>
 Phone: 1-800-442-6003
 TTY: Maine relay 711

Private Health Insurance Premium Webpage:
<https://www.maine.gov/dhhs/ofi/applications-forms>
 Phone: 1-800-977-6740.
 TTY: Maine relay 711

MASSACHUSETTS – MEDICAID AND CHIP

Website: <https://www.mass.gov/masshealth/pa>
 Phone: 1-800-862-4840

MINNESOTA – MEDICAID

Website:
<https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
 Phone: 1-800-657-3739

MISSOURI – MEDICAID

Website:
<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
 Phone: 573-751-2005

MONTANA – MEDICAID

Website:
<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
 Phone: 1-800-694-3084

NEBRASKA – MEDICAID

Website: <http://www.ACCESSNebraska.ne.gov>
 Phone: 1-855-632-7633
 Lincoln: 402-473-7000
 Omaha: 402-595-1178

NEVADA – MEDICAID

Medicaid Website: <http://dhcfp.nv.gov>
 Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – MEDICAID

Website: <https://www.dhhs.nh.gov/oii/hipp.htm>
 Phone: 603-271-5218
 Toll free number for the HIPP program:
 1-800-852-3345, ext. 5218

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
 Medicaid Phone: 609-631-2392
 CHIP Website: <http://www.njfamilycare.org/index.html>
 CHIP Phone: 1-800-701-0710

NEW YORK – MEDICAID

Website: https://www.health.ny.gov/health_care/medicaid/
 Phone: 1-800-541-2831

NORTH CAROLINA – MEDICAID

Website: <https://medicaid.ncdhhs.gov/>
 Phone: 919-855-4100

NORTH DAKOTA – MEDICAID

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
 Phone: 1-844-854-4825

OKLAHOMA – MEDICAID AND CHIP

Website: <http://www.insureoklahoma.org>
 Phone: 1-888-365-3742

OREGON – MEDICAID

Website: <http://healthcare.oregon.gov/Pages/index.aspx> or
<http://www.oregonhealthcare.gov/index-es.html>
 Phone: 1-800-699-9075

PENNSYLVANIA – MEDICAID

Website: <https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx>
 Phone: 1-800-692-7462

RHODE ISLAND – MEDICAID AND CHIP

Website: <http://www.eohhs.ri.gov/>
 Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – MEDICAID

Website: <https://www.scdhhs.gov>
 Phone: 1-888-549-0820

SOUTH DAKOTA - MEDICAID
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS - MEDICAID
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH - MEDICAID AND CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT- MEDICAID
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA - MEDICAID AND CHIP
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
WASHINGTON - MEDICAID
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA - MEDICAID AND CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - MEDICAID AND CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING - MEDICAID
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employmentbased health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Shannon Scott, Director of Total Rewards, Eagle Family Foods Group LLC, 1975 E. 61st St., Cleveland, OH 44103.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)	
5. Employer address	6. Employer phone number	
7. City	8. State	9. Zip code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - All employees. Eligible employees are:
 - Some employees. Eligible employees are:
- With respect to dependents:
 - We do offer coverage. Eligible dependents are:
 - We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months? <input type="checkbox"/> Yes (Continue) 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue) <input type="checkbox"/> No (STOP and return this form to employee)
14. Does the employer offer a health plan that meets the minimum value standard*? <input type="checkbox"/> Yes (Go to question 15) <input type="checkbox"/> No (STOP and return form to employee)
15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs. a. How much would the employee have to pay in premiums for this plan? \$ _____ b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? <input type="checkbox"/> Employer won't offer health coverage <input type="checkbox"/> Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.) a. How much would the employee have to pay in premiums for this plan? \$ _____ b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



— THE —
University of Vermont
HEALTH NETWORK

— THE —
University of Vermont
MEDICAL CENTER