The heart of science and medicine.

THE University of Vermont HEALTH NETWORK

Home Health & Hospice

BENEFITS GUIDEBOOK

2024

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.

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

Open Enrollment: Take Action!

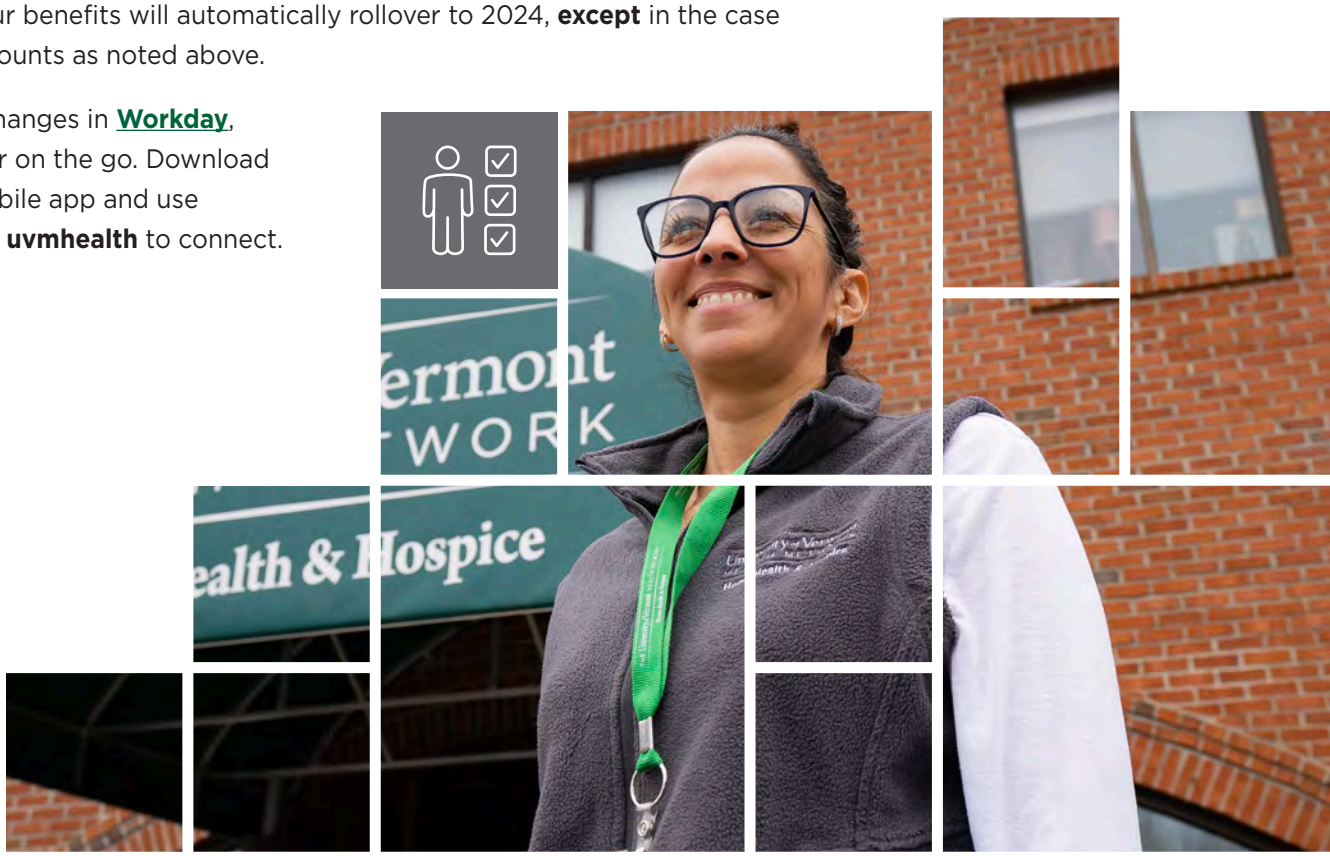
November 6 - November 17, 2023

During Open Enrollment you can:

- **Enroll in Coverage**
- **Add & Remove Dependents**
- **Make Changes to Your Benefits**
- **Re-Enroll in Spending Accounts:** You **must re-enroll** to contribute to a Flexible Spending Account (FSA) or Health Savings Account (HSA) in 2024. Spending Accounts **do not automatically rollover**.

All enrollments and changes will be effective January 1, 2024. If you do not make any changes, your benefits will automatically rollover to 2024, **except** in the case of Spending Accounts as noted above.

Enroll or make changes in **Workday**, access at work or on the go. Download the Workday mobile app and use **Organization ID: uvmhealth** to connect.



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

Important Contacts

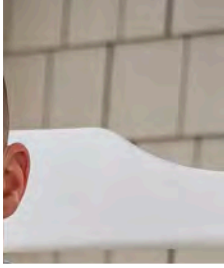
HR Contact Information

CONTACT	PHONE	EMAIL	WEBSITE
HR Solution Center (HRSC) Monday – Friday 7:30am – 5pm EST	844-777-0886	HRSolutionCenter@UVMHealth.org	UVMHN Benefits Website
Payroll Monday – Friday 8am – 4:30pm EST	802-847-3760	Payroll@UVMHealth.org	
Leave of Absence	844-777-0886	LOA@UVMHealth.org	
Employee Assistance Program (EAP)	866-660-9533		Invest EAP
Employee Health	802-658-1900 xt 3313	Employeehealth@uvmhomehealth.org	

Vendor Contact Information

COVERAGE	CONTACT	GROUP NO.	PHONE	WEBSITE
Medical	Blue Cross Blue Shield	71-5943Q	833-578-1126	myhealthtoolkitvt.com
Prescription	Navitus	UVMB	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

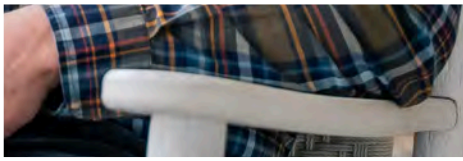


Home Health & Hospice (HHH) is excited to expand our definition of part-time for benefits eligibility in 2024!

Previously, employees classified at .5 to .7 FTE were not considered benefit eligible. If you are in this category, you are now eligible to enroll in HHH benefits during Open Enrollment.

To confirm if you are a .5 to .7 FTE, go to **Workday**, click on your picture (top right), click View Profile. On the right, under Job Details your FTE is listed above Location.

If you need help with Workday contact the HR Solution Center at 844-777-0886.



To participate in the UVM Health Network (UVMHN)/HHH benefits, you must be classified as a full or part-time employee (40-80 hours) bi-weekly.

- **Full-Time:** Hired to regularly work 72–80 hours bi-weekly
- **Part-Time 1:** Hired to regularly work 60-71 hours bi-weekly
- **Part-Time 2:** Hired to regularly work 40-59 hours bi-weekly

WHEN DOES MY COVERAGE START?

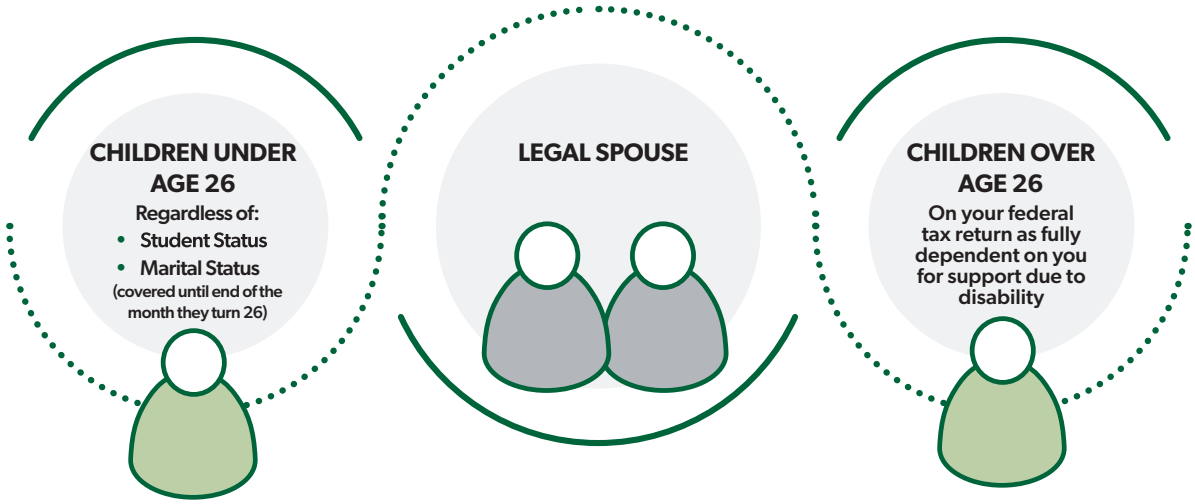
Coverage begins the first of the month following your date of hire or any change that makes you benefits-eligible. If your date of hire or benefits eligibility date is the first day of the month, your benefits begin that day.

EXAMPLE:

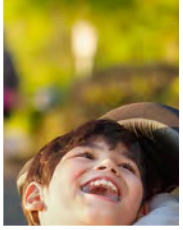
- **Hire Date:** January 15
- **Time to Enroll in Coverage:** January 15 - February 15 (31 days)
- **Coverage Starts:** February 1

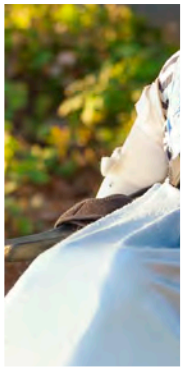
  NOTE: The 31 days allowed to enroll extends after the day coverage starts. If you enroll after the coverage start date, you are responsible for any missed contributions, which will be deducted from your paycheck.

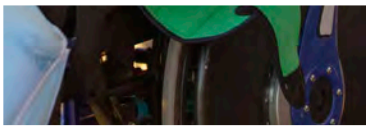
You may also enroll your eligible dependents. If you enroll in benefits, you can cover your:



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 email them to the HR Solution Center or call at 844-777-0886 for assistance.

DATE OF HIRE OR BENEFIT ELIGIBILITY DATE

Dependent Verification documents must be provided **within 60 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 network partners 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 IRS requirements, which include complying with benefits eligibility, enrollment and qualifying life event rules.

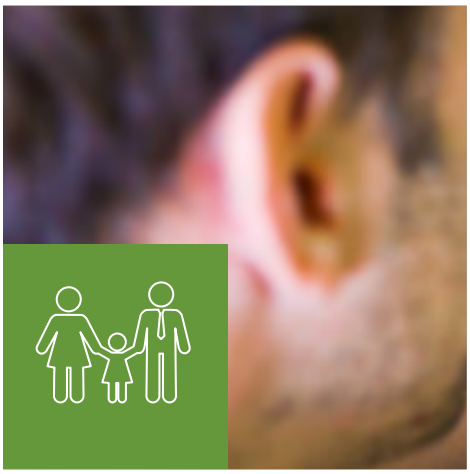
Changing Benefits After Enrollment

During the year, you cannot make changes to your benefits unless you have an IRS 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 as noted 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	▪ Employee ▪ Spouse ▪ Eligible Dependent(s)	Elections/Changes must be made by the last day of Open Enrollment.	January 1	OE Period: 11/6 - 11/17 Coverage starts 1/1
Loss of Coverage/ Eligibility Under Another Group Plan	▪ 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	▪ Employee ▪ Spouse ▪ Dependent(s)	31 days from loss of coverage/ eligibility date	Date of loss	Coverage ends on 2/15 Enroll 2/16 - 3/18 Coverage starts on 2/16
Gain Other Coverage	Gain coverage through spouse/ parent as a result of new hire enrollment, open enrollment, employment change	▪ Employee ▪ Spouse ▪ Dependent(s)	31 days from gain in coverage date	Date before new coverage begins	Coverage starts on 3/1 Cancel coverage 3/1 - 4/1 Coverage ends on 2/28
Marriage	Get Married	▪ Spouse ▪ Dependent(s)	31 days from marriage date	Date of marriage	Date of Marriage 3/10 Enroll 3/11 - 4/11 Coverage starts on 3/10

Changing Benefits After Enrollment

IRS Qualified Life Event	Events	Changes Apply To	Time Allowed To Make Changes	Effective Date Of Change	Timeline Examples
Family Status Change	▪ Birth of Child ▪ Adoption or Placement for Adoption ▪ Legal Guardianship Appointment	▪ Employee ▪ Spouse ▪ Eligible Dependent(s)	60 days from change in Family Status	Date of change in Family Status **Birth of Child:** see Reminder below **Adoption/Legal Guardianship:** You must call HRSC to add child at no charge for the first 60 days.	Date of Birth: 05/05 Enrollment window: 05/05-07/05 Effective date of coverage: 05/05
IMPORTANT REMINDER – Adding Newborn to UVMHN Medical Plan: If you are enrolled in a UVMHN medical plan your newborn will automatically be added to coverage for the first 60 days at no charge. If you want your newborn to continue coverage beyond the first 60 days, **you must contact the HR Solution Center within 60 days from their date of birth** to add your newborn to coverage. If you **do not** contact the HR Solution Center **within 60 days from the date of birth**, your **newborn will be removed** from your medical plan. If your newborn is removed from your medical plan, this is considered a voluntary termination and **COBRA will not be offered**. The next opportunity to add your newborn will be during the annual Open Enrollment period in November and coverage will be effective January 1 of the following year.					
Loss of Coverage Medicaid Children's Health Insurance Program (CHIP)	Medicaid or CHIP coverage terminates	▪ Employee ▪ Eligible Dependent(s)	60 days from loss of coverage	Date of loss	Date of Loss 7/14 Enroll 7/14 - 9/12 Coverage starts on 7/14
Become Eligible for Premium Assistance Medicaid Children's Health Insurance Program (CHIP)	Become eligible for premium assistance under Medicaid or CHIP	▪ Employee ▪ Eligible Dependent(s)	60 days from becoming eligible for premium assistance	Date before coverage begins	Eligibility Date/Coverage Begins 9/22 Cancel Coverage 9/22 - 11/21 Coverage ends on 9/21



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 60 days from enrolling** (see page 6).

3. **ENROLL IN WORKDAY**
   Workday is the cloud-based HR, Payroll and Benefits system for UVMHN. Need help logging into **Workday**? Call the IS Help desk 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 60 days** (see page 6). **IMPORTANT:** If you do not upload the dependent verification documents **within 60 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!

- **Phone:** 844-777-0886
- **Email:** HRSolutionCenter@UVMHealth.org
- **Hours:** Monday – Friday, 7:30am – 5pm EST
- **UVMHN Benefits Website**

PAYCHECK OR TAX WITHHOLDING QUESTIONS?

Payroll is available to answer your questions.

- **Hours:** Monday – Friday, 8:00am – 4:30pm EST
- **Email:** Payroll@UVMHealth.org
- **Phone:** 802-847-3760

ACCESS WORKDAY ON THE GO!

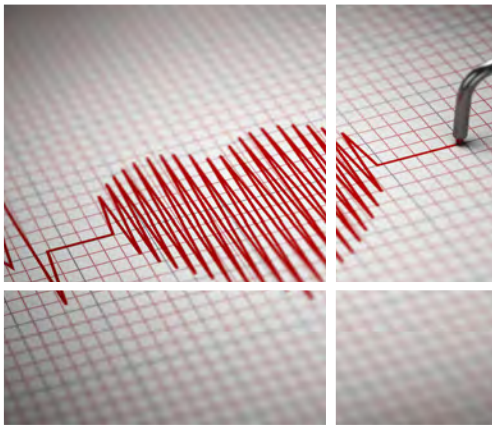
To access **Workday** click your **profile picture** (top right), click **My Account**, click **Organization ID** and scan the **QR code** to sign in from your phone.

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%.

BCBS National Network

All four medical plans have four 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 1600 & 3200** 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 deducible amounts and specify that individual deductibles cannot apply.

Medical Plans

Register Online

Your connection to great health care is only a click away. Register for an online account at **myhealthtoolkitvt.com** so you can access time-saving tools, tips for healthy living, view lab results, choose a doctor, manage your EOBs, and more!

Download the Mobile App

Get a digital ID card using the Blue Cross Shield My Health Toolkit mobile app. You can view claims, EOBs and more all from your smartphone. The mobile app is available for download on Google Play and the App Store.

Download on the App Store | GET IT ON Google Play

Your medical plans are offered through Blue Cross Blue Shield. Please review the Summary of Benefits and Coverage (SBC) by clicking the Plan names in the Medical Plan Comparison charts (pg. 12-13) or on the **UVMHN Benefits website** for additional coverage information and full plan details.

You may visit any medical provider you choose, but Tier 1 / Tier 2 providers offer the highest level of benefits and lower out-of-pocket costs.

Understanding Your Plan Options

250 Plan In-Network: Deductible $250 (individual) $750 (family)

400 Plan In-Network: Deductible $400 (individual) $1,200 (family) — These plans have an **Embedded Deductible**. Each family member has an individual deductible in addition to the overall family deductible. This means that, if an individual in the family reaches his or her deductible before the family deductible is reached, his or her services will be paid by the insurance company.

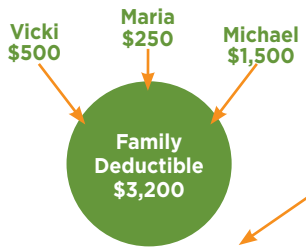
HDHP 1600 In-Network: Deductible $1,600 (individual) $3,200 (family)

HDHP 3200 In-Network: Deductible $3,200 (individual) $6,400 (family) — The HDHPs have an **Aggregate Deductible**. All family members' out-of-pocket expenses count toward the family deductible until it is met. It doesn't matter if one person incurs all the expenses that meet the deductible or if two or more family members contribute toward meeting the family deductible.

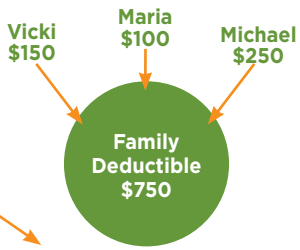
Deductible Aggregate vs. Embedded

Deductible: Amount you pay before the Plan pays.
Plan Year is January – December and the deductible resets in January.

Aggregate Family Deductible: HDHP w/HSA 1600 & 3200 Plans
Plan pays for the services of all family members after the full family deductible is met.



Embedded Family Deductible: 250 & 400 Plans
The Plan pays for the services of the individual family members who have reached the individual deductible.



HDHP 1600 Family: No, an additional $950 must be applied to meet the family deductible. The Plan will not pay until the full family deductible is met.

250 Family Plan: Yes, Michael has met his individual deductible and the Plan will pay for his services. $500 has been applied to the family deductible, it will be met when Vicki and Maria combined meet an additional $250 or if one of them meets the additional $250.

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 and Tier 2/In-Network, which includes UVMHN facilities and providers. Click on the medical plan names (250 Plan, 400 Plan, HDHP 1600, HDHP 3200) 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 BCBS Providers Only		Not Covered	No Charge BCBS Providers Only		Not Covered

BlueCross BlueShield

PREFERRED PROVIDER ORGANIZATION (PPO)						
	Tier 1/Domestic	1600 Plan		Tier 1/Domestic	3200 Plan	
	NETWORK	IN NETWORK	OUT NETWORK	NETWORK	IN NETWORK	OUT NETWORK
General Medical						
Coinsurance	10%	20%	30%	10%	20%	0%
Deductible	$1,600/$3,200		$3,000/$6,000	$3,200/$6,400		$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		
UVMHN HSA Funding	$533/$1,067			$1,067/$2,133		
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% BCBS Providers Only	100%	Not Covered	100% BCBS Providers Only	100%	Not Covered

Prescription Drug Plan

NAVITUS

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 1600 & 3200	
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

Get your medications delivered at no extra charge from the UVM Health Network's Mail Order Pharmacy.

- **Skip the drive** – receive lower network pharmacy co-pays
- **We track renewals for you** – never get stuck without your meds
- **Free refill reminders** by phone, text or email. Sign up is easy call 802-847-3784. We're available Monday - Friday, 8:30am - 5pm to get started today.
- **Learn more** at UVMHealth.org/MailOrderRx

Available on the App Store

GET IT ON Google Play

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.

Out-of-State Residents: Employees and dependents who reside out-of-state full time must live in one of the following states to receive prescriptions via mail. Arizona, Colorado, Connecticut, Delaware, Florida, NH, NJ, NY, Pennsylvania, Rhode Island, South Carolina.

How an HDHP Works

Under the HDHP 1600 and HDHP 3200 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: $1,792.60**
- Deductible $1,600
- Coinsurance 10% $192.60
- Assumes single coverage under the HDHP 1600 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)

HealthEquity

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. **CANADIAN RESIDENTS:** If you are eligible for Canada's publicly funded health care system you **are not** eligible to contribute to an HSA. Please contact the HR Solution Center to review your options.

HOW HSAs WORK

CONTRIBUTIONS

UVMHN + Your Contributions combined may not exceed the IRS annual maximums.

- **HDHP 1600 UVMHN contributes:**
  $533 (Employee Only) | $1,067 (Family)
- **HDHP 3200 UVMHN contributes:**
  $1,067 (Employee Only) | $2,133 (Family)

IMPORTANT REMINDER: If required, you must verify your identity with HealthEquity, you will receive an email from HealthEquity (sent to your work email) or you can call HealthEquity at 866-346-5800. If you **do not verify your identity** your **contributions will remain in a Suspense Account** and will not be deposited to your HSA until you verify your identity. **The UVMHN contribution will not be made until you verify your identity with HealthEquity**.

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 $4,150 if you enroll in single coverage or $8,300 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 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 such as through a spouse, parent, or another employer (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 Full Purpose Health Care Flexible Spending Account (HCFSA). Regardless of your HSA eligibility, you can still be enrolled in the HDHP 1600 or HDHP 3200 plan.

You must re-enroll in the HSA

it does not roll over automatically.

Health Savings Account (HSA)

HealthEquity

HSA = 3 TAX ADVANTAGES!

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

HSA 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 1600 Single:** $533
- **HDHP 1600 Family:** $1,067
- **HDHP 3200 Single:** $1,067
- **HDHP 3200 Family:** $2,133

UVMHN will deposit half of their contribution in January and the remaining amount will be deposited evenly each month. Employees who enroll after January 1 will receive prorated amounts. See the **UVMHN HSA Contributions** schedule on page 58.

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

HSA ELIGIBLE EXPENSES Examples:

- **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 here or 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 features 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 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.

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.

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 1600 & 3200 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.

REMINDER: USE IT OR LOSE IT

You have until May 31 to submit expenses for 2024. Any funds greater than $610 not spent by May 31 will be forfeited, per IRS rules. See Carryover Benefit below.

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.

EXAMPLE: If you elected $2,000 for your 2024 Health Care FSA and spend $1,000 by December 31, 2024 you will have until May 31, 2025 to file 2024 expenses. If you do not have $390 in expenses from 2024 to claim for reimbursement, you will forfeit the $390 and $610 will carry over to the 2025 plan year.

HealthEquity®

NOTE: These are the 2023 FSA limits, the limits will be updated when the IRS provides the 2024 limits.

Using Your FSA Money

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

- **Pay by Debit 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.

You May Be Required To Submit Receipts For Expenses Paid Using Your Debit Card

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

HELPFUL INFORMATION:

- Dependent Care Guide
- FSA General Purpose
- FSA Limited Purpose

DEPENDENT CARE – GRACE PERIOD

While there is no carryover for Dependent Care FSA (DCFSA), 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, 2025 to incur expenses that can be paid for using funds remaining from the 2024 plan year.

EXAMPLE: If you have $300 remaining at the end of the plan year (December 31, 2024), those funds will remain available for you to use for eligible expenses until March 15, 2025. You have until May 31, 2025 to submit those 2024 eligible expenses for reimbursement.

REMINDER: IRS rules state FSAs cannot favor Highly Compensated Employees (HCEs). After completing non-discrimination testing (NDT) for the UVMHN FSA plans, HCEs may have their DCFSA elections reduced and there may be taxation on any reimbursements over the limits produced from NDT. HCEs are those who receive more than $150,000 in compensation for the 2023 tax year.

HSA & FSA Comparison

HealthEquity

This chart shows the features of the health care FSAs and the Health Savings Account (HSA) and compares the limited purpose health care FSA to the full purpose health care FSA. **NOTE:** These are the 2023 FSA limits, the limits will be updated when the IRS provides the 2024 limits.

	HSA*	Limited Purpose Health Care FSA**	Full Purpose Health Care FSA***
Medical Plan	HDHP 1600 HDHP 3200	HDHP 1600 HDHP 3200	250 Plan 400 Plan
How much you may contribute (less the UVMHN contribution)	HDHP 1600 $3,617 (Single) $7,233 (Family) HDHP 3200 $3,083 (Single) $6,167 (Family) Catch-up contributions of up to **$1,000** per year for age 55+	Up to **$3,050** for plan year	
Expenses you may pay from your account	Out of pocket Medical Prescription drug Dental Vision Long-term Care premiums	Out of pocket expenses incurred during the current calendar year (including the grace period): Dental Vision	Medical Prescription drugs Dental Vision
Account balance available to reimburse expenses	Current account balance	Entire contribution amount elected for the plan year	
Time limits for using your account balance	No limit	Must use 2024 account balance for expenses incurred through **December 31, 2024**; Claims must be filed by **May 31, 2025**	
If you don't use all your account balance each year	Any account balance carries over from year to year	You may carryover up to $610 of unused funds into the next plan year. If you have more than $610 remaining by May 31, 2025 the amount over $610 will be forfeited. EXAMPLE: If you elected $2,000 for your 2024 Health Care FSA and spend $1,000 by December 31, 2024 you will have until May 31, 2025 to file 2024 expenses. If you do not have $390 in expenses from 2024 to claim for reimbursement, you will forfeit the $390 and $610 will carry over to the 2025 plan year.	
How it saves you money	Your contributions are tax free, which reduces your taxable income Any investment or interest earnings on your account balance is tax free Distributions are tax free if used for qualified healthcare expenses	Your contributions are tax-free, which reduces your taxable income and increases your take-home pay You pay for healthcare expenses with pre-tax dollars	

* If you are eligible for Canada's publicly funded health care system you are not eligible to contribute to an HSA. Please contact the HR Solution Center to review your options.

** The Limited Purpose FSA is available to employees who enroll in the HDHP 1600 or 3200. HDHP members may not enroll in the Full Purpose Health Care FSA, unless you are not eligible to participate in the HSA. If you have questions, contact the HR Solution Center.

*** You don't have to be enrolled in a UVMHN medical plan to enroll in a healthcare FSA.

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, WITH THE HDHP 1600 or 3200 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!

Medical Rates

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	$83.44	$333.76	$2,169	$10,847
2 Person	$166.92	$667.71	$4,340	$21,700
Family	$221.16	$884.62	$5,750	$28,750
Premier 400	**Your Cost**	**UVMHN**		
1 Person	$79.84	$319.34	$2,076	$10,379
2 Person	$159.72	$638.86	$4,153	$20,763
Family	$211.60	$846.40	$5,502	$27,508
HDHP 1600	**Your Cost**	**UVMHN**		
1 Person	$65.75	$299.51	$1,710	$9,497
2 Person	$131.53	$599.20	$3,420	$18,999
Family	$174.44	$794.65	$4,535	$25,196
HDHP 3200 ($10.78-$20.06)	**Your Cost**	**UVMHN**		
1 Person	$15.19	$322.37	$395	$8,777
2 Person	$54.02	$621.27	$1,405	$17,558
Family	$80.69	$815.92	$2,098	$23,312
HDHP 3200 ($20.07-$31.72)	**Your Cost**	**UVMHN**		
1 Person	$46.25	$291.31	$1,202	$8,777
2 Person	$104.67	$570.62	$2,721	$17,558
Family	$142.11	$754.50	$3,695	$23,312
HDHP 3200 ($31.73+)	**Your Cost**	**UVMHN**		
1 Person	$60.77	$276.79	$1,580	$8,777
2 Person	$121.55	$553.74	$3,160	$17,558
Family	$161.39	$735.22	$4,196	$23,312

Medical Rates

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	$112.64	$304.56	$2,929	$10,847
2 Person	$225.35	$609.28	$5,859	$21,700
Family	$298.56	$663.47	$7,763	$25,013
Premier 400	**Your Cost**	**UVMHN**		
1 Person	$107.78	$291.40	$2,802	$10,379
2 Person	$215.61	$582.96	$5,606	$20,763
Family	$285.66	$772.34	$7,427	$27,508
HDHP 1600	**Your Cost**	**UVMHN**		
1 Person	$98.62	$266.64	$2,564	$9,497
2 Person	$197.30	$533.43	$5,130	$18,999
Family	$261.66	$707.43	$6,803	$25,196
HDHP 3200 ($10.78-$20.06)	**Your Cost**	**UVMHN**		
1 Person	$16.71	$320.85	$434	$8,777
2 Person	$59.43	$615.87	$1,545	$17,558
Family	$88.76	$807.85	$2,308	$23,312
HDHP 3200 ($20.07-$31.72)	**Your Cost**	**UVMHN**		
1 Person	$50.87	$286.69	$1,323	$8,777
2 Person	$115.14	$560.16	$2,994	$17,558
Family	$156.32	$740.29	$4,064	$23,312
HDHP 3200 ($31.73+)	**Your Cost**	**UVMHN**		
1 Person	$66.84	$270.72	$1,738	$8,777
2 Person	$133.71	$541.59	$3,476	$17,558
Family	$177.53	$719.08	$4,616	$23,312

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	$166.88	$250.32	$4,339	$10,847
2 Person	$333.85	$500.78	$8,680	$21,700
Family	$442.31	$663.47	$11,500	$28,750
Premier 400	**Your Cost**	**UVMHN**		
1 Person	$159.67	$239.51	$4,151	$10,379
2 Person	$319.43	$479.14	$8,305	$20,763
Family	$423.20	$634.80	$11,003	$27,508
HDHP 1600	**Your Cost**	**UVMHN**		
1 Person	$138.80	$226.46	$3,609	$9,497
2 Person	$277.68	$453.05	$7,220	$18,999
Family	$368.26	$600.83	$9,575	$25,196
HDHP 3200 ($10.78-$20.06)	**Your Cost**	**UVMHN**		
1 Person	$50.46	$287.10	$1,312	$8,777
2 Person	$126.96	$548.34	$3,301	$17,558
Family	$178.42	$718.19	$4,639	$23,312
HDHP 3200 ($20.07-$31.72)	**Your Cost**	**UVMHN**		
1 Person	$84.63	$252.93	$2,200	$8,777
2 Person	$182.67	$492.63	$4,749	$17,558
Family	$245.99	$650.63	$6,396	$23,312
HDHP 3200 ($31.73+)	**Your Cost**	**UVMHN**		
1 Person	$100.60	$236.96	$2,616	$8,777
2 Person	$201.24	$474.06	$5,232	$17,558
Family	$267.19	$629.42	$6,947	$23,312

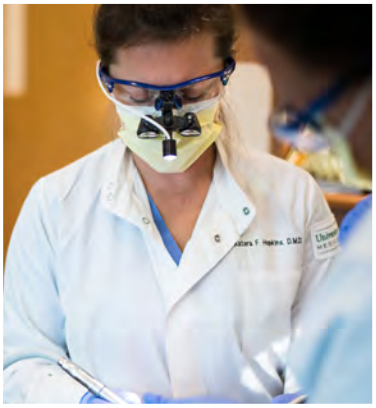
Dental

DELTA 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	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** to find a dentist, view claims, benefits, print ID cards and more!



Dental Rates

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

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	$13.92	$195	$557
2 Person	$13.69	$25.43	$356	$1,017
Family	$24.94	$46.32	$648	$1,853

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	$1,496
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 Plan

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** to find an eye doctor or call VSP at 800-877-7195.

	VSP	
	Core Plan	Buy-up Plan
BENEFIT	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

Full-Time/Part-Time 1/Part-Time 2

PLAN	BI-WEEKLY PRE-TAX COST SHARE		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

Basic Life Insurance/AD&D

Term Life Insurance

UVMHN/HHH provides financial protection with *Basic Life and Accidental Death & Dismemberment (AD&D) Insurance at no cost to you. Benefit eligible employees can choose $50,000 or 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:** Benefits eligible employees are eligible the first of the month following their date of hire or benefits eligibility date. Health information **is not** required.

****ADDITIONAL LIFE:** You can purchase up to the maximum amounts in the image above. If you elect amounts over the Guaranteed Issue Amounts below health information **is required** and subject to approval by The Hartford.

Additional Life Guaranteed Issue Amounts – Employee: $200,000 **Spouse:** $50,000

Life Insurance

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 2024, 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.

IMPUTED INCOME

The IRS requires you to pay income tax on the value of any life insurance amount exceeding $50,000. The IRS determined value is called imputed income and is calculated from the government's Uniform Premium Table I.

If you enroll in the 2x Basic Life benefit the value of life insurance 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
Annual Imputed Income (Amount Taxed): $40.56 (1.56 per pay period)

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**

Life Insurance

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 email 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. 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 move to 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.

Disability

STD & LTD

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

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 receive STD after 6-months of employment and part-time employees receive after 12-months of employment. You are automatically enrolled once you become eligible.

Long-Term Disability (LTD)

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

Maternity Leave

Maternity Leave is covered through the STD plan. 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

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 go to

MyHealthToolkitVT.com create an account or log in

Go to Wellness & Click Maternity

To participate you must be enrolled in a UVMHN BCBS medical plan. This benefit is available to the parent enrolled, including adoptive parent, biological parent and same-sex couples.

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
- Call The Hartford

BENEFIT PROVIDED BY:

The Hartford

Contact: 888-716-4549

Group Number: 697296

Website: TheHartfordMyBenefits

USE WEBSITE TO:

- Start a Claim
- Check Claim Status

DISABILITY PLANS:

- Short-Term Disability
- Long-Term Disability

PREMIUMS:

- Paid by UVMHN

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 35 days of service with a 3% pre-tax contribution, which can be changed at any time.

IF YOU ARE

AGE 50 or older

by the end of the calendar year you can make an additional contribution of

$7,500

Increase Your Retirement Savings With a 403(b)

TYPES OF 403(b) CONTRIBUTIONS

Matching Contribution*

Employee Contribution

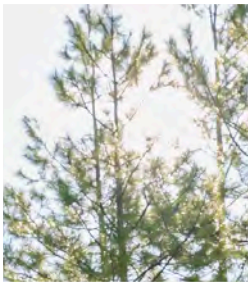
Employee contributions cannot exceed the IRS limit of

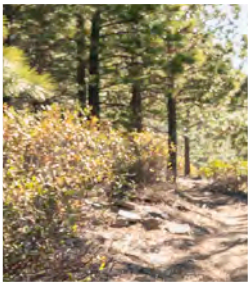
$22,500**

* **Matching Contribution:** If eligible, HHH will make an annual 100% match on the first 3% of employee contributions.

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

NOTE: These are the 2023 limits, the limits will be updated when the IRS provides the 2024 limits.





Vesting

You are immediately 100% vested in your employee and employer contributions.

403(b) Retirement Plan

Enrollment, Automatic Enrollment, & Opting Out

You may begin contributing to the plan at any time. If you do not take any action, you will be automatically enrolled into the 403(b) Retirement Plan after 35 days 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 (fulltime, 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:

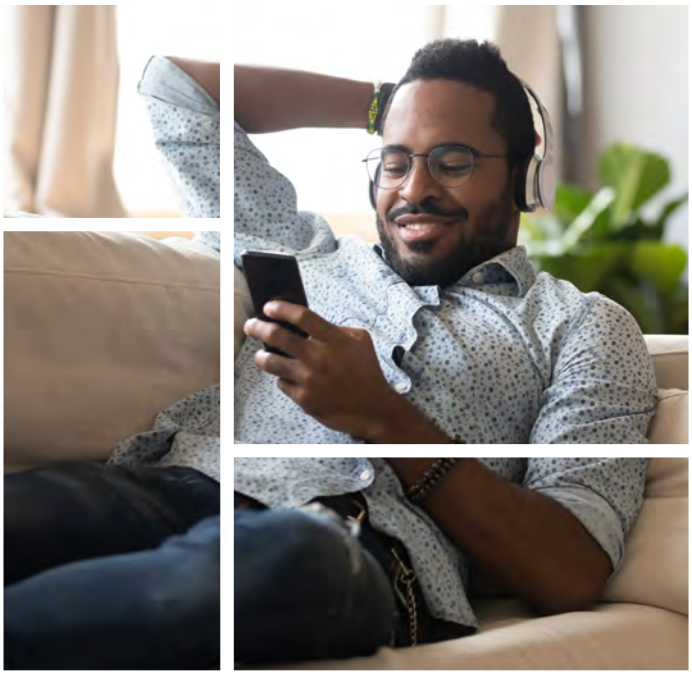
1. **Log on to NetBenefits at netbenefits.com/uvmhealth. Click Register as a New User and follow prompts to establish a user name and password. You will need a code that will be sent to your work email account.**
2. **Call Fidelity at 800-343-0860.**

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 pre-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.

YOU MAY CHANGE YOUR CONTRIBUTION AT ANY TIME



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
- Fidelity Mobile App
- Summary Plan Description

403(b) Retirement Plan

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.

NOTE: These are the 2023 limits, the limits will be updated when the IRS provides the 2024 limits.

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 401(k)/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 Matching Contribution

Subject to eligibility, Home Health & Hospice will make a bi-weekly match of 100% on the first 3% of employee contributions.

To be eligible for the matching contribution, you must be employed for at least one year and have at least 1,000 hours worked during that year.

If you work 1,000 or more hours during your first year of employment, you become eligible for the match beginning the pay period after you meet the 1,000 hour eligibility criteria.

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

Vesting

You always own any contributions you make to your retirement account.

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

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 lineup 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. UVMHN 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.

403(b) Retirement Plan

Rehire & Service Time Information

If you worked at UVMMC or any UVMHN Network Partner within the past five years and have been rehired, your previous employment will be used to determine employer contribution eligibility. For vesting, you always retain time earned regardless of breaks in service. Please contact the HR Solution Center at 844-777-0886 if you believe this may apply to you.

One-on-One Consultations

Fidelity hosts frequent on-site visits for one-on-one meetings. To schedule an appointment, call 800-248-4213 or **click here** If you are not able to find an "in-person" appointment at a convenient location, select the "virtual appointment" option.

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 can designate or update your Beneficiary by clicking on the Profile & Settings icon at the top right hand of your home page.

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 59 1/2
- You become disabled
- You experience a financial hardship
- You are in need of a 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":

Corebridge Financial, formerly AIG - VALIC
Group: 44310
Client Care Center (800) 448-2542
www.corebridgefinancial.com

Wellness

Wellness is the complete integration of body, mind and spirit and everything you do, think, feel and believe has an effect on your overall well-being.

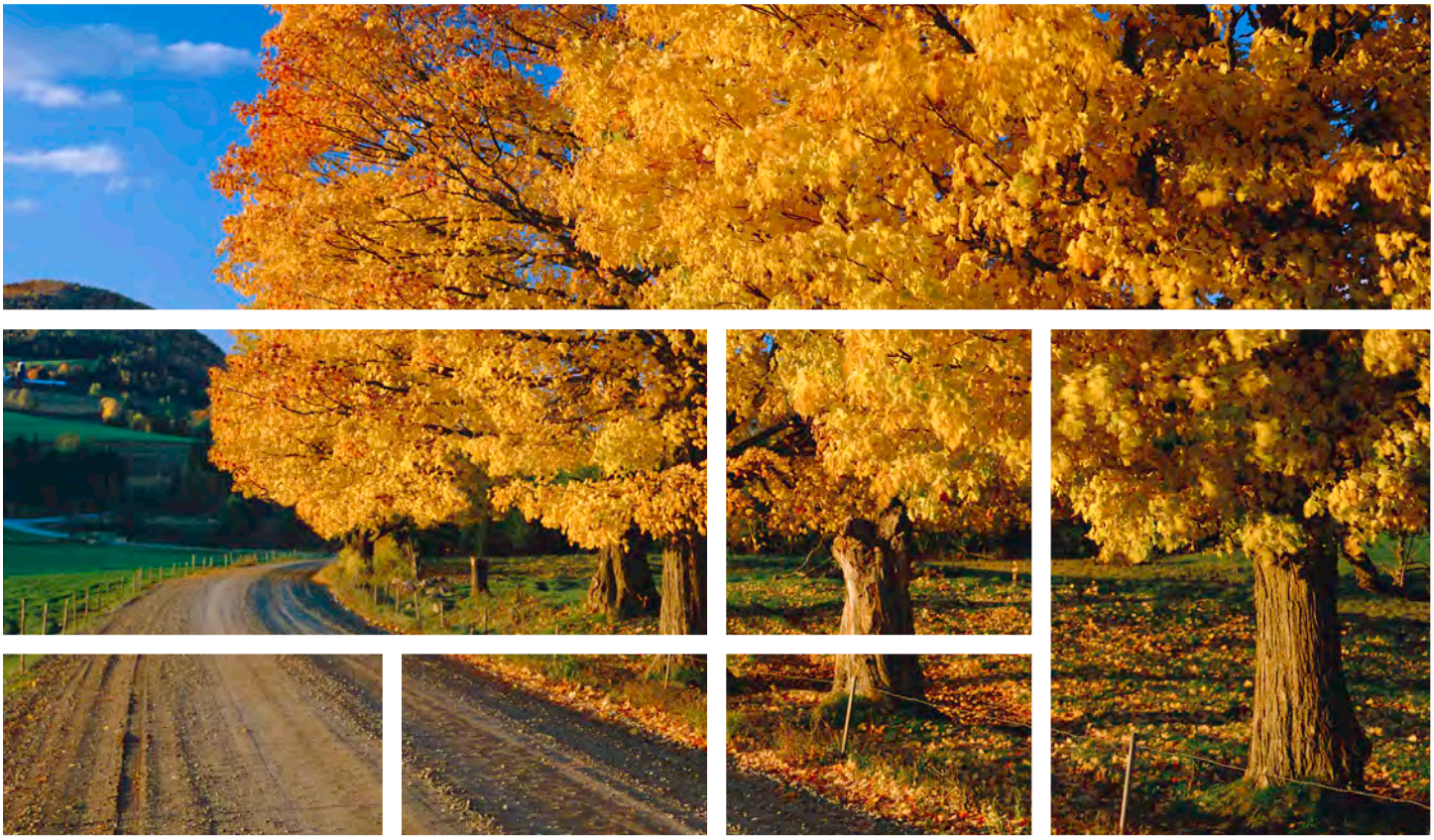
Your overall well-being is an ongoing process and life-long journey, not a one-time event. We encourage you to explore the different interconnected dimensions of well-being, which include: **Physical, Emotional, Spiritual, Social, Intellectual, Financial, Environmental/Community, Work-Life** (career fulfillment and work-life balance).

Taking care of ourselves enables us to take care of others. When you invest in self-care, you are taking the time to do things that help you live well and improve your overall well-being. Common self-care activities include exercise, sleep, balanced nutrition, meditation, connecting with family and friends, but it also includes taking care of ourselves by:

- Asking for help
- Spending time alone
- Putting yourself first
- Asking for what you need
- Setting boundaries
- Staying at home
- Saying “no”
- Forgiving yourself
- Taking a step back
- Pampering yourself

To support your well-being, we encourage you to use the wellness resources and participate in the wellness programs and activities available at Elizabethtown Community Hospital.

- Monthly Communications
- Onsite Fitness Center
- Employee Counseling
- Strozzi Resiliency
- Working Bridges



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.

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

New In 2024 – Friends & Family Plan

UVMHN is excited to provide additional support for your loved ones! Starting January 2024, you can add up to 5 family members or friends to your Headspace membership at no cost. Invite them to join using their email address on the Manage Accounts page. They must be 18 or older to join.

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 HHH email, you will receive two emails from Headspace
4. **Existing Members:** verify your account with your HHH 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

Download on the App Store GET IT ON Google Play

Click the links below to:

- **LESS STRESS, MORE PROGRESS**
- **TAKE A BREAK - BREAK A SWEAT**
- **PUT YOUR MIND TO BED**

Employee Assistance Program

Employee Assistance Program (EAP) is designed to provide free, confidential support for employees and adult household family members. The EAP 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.

USE EAP FOR HELP WITH

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

TYPES OF SERVICES

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

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

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.

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

If you need help, contact toll-free, 24 hours a day, seven days a week, by calling 866-660-9533 or visit, **INVESTEAP.ORG**

PASSWORD: HomeHealth

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. Major organ failure

To learn more visit the **UVMHN Voya Employee Benefits Resource Center** or the Voluntary Benefits section of the **UVMHN Benefits website**.

Voluntary Benefits
Accident, Illness, Hospital cont.

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

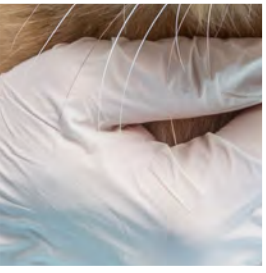
Allstate Identity Protection

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

CANDADIAN RESIDENTS: Restrictions apply, contact Allstate at 800-789-2720 for details.



Pet Insurance

Nationwide

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.

Voluntary Benefits
ID Protection & Pet Insurance

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

- **Pet Insurance Overview**
- **FAQ – Pre-enrollment**
- **FAQ – Post-Enrollment**
- **FAQ – Claim Reimbursement**
- **Vitus Vet**
- **Vet Helpline®**

Combined Time Off (CTO)

Holidays

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

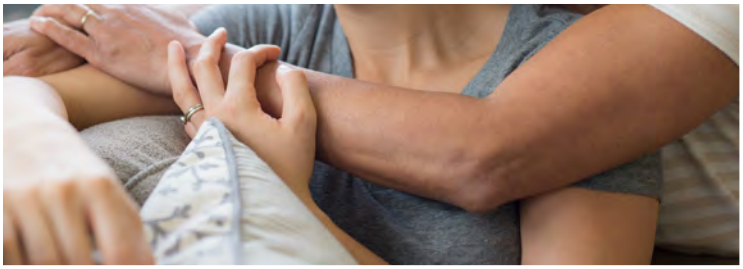
Home Health & Hospice recognizes the varying time off needs of staff. Staff identified as regular full-time or regular part-time will be eligible to receive CTO.

The below chart outlines the accrual rate for a fulltime employee. The accrual is based on scheduled hours per pay period.

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

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

Extended Sick Time



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

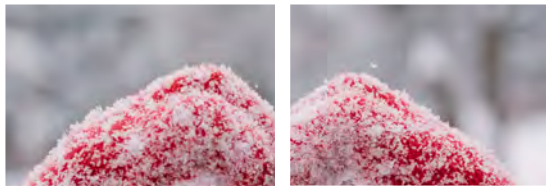
Extended Sick time can also be used for a family member's illness on the fourth day of lost time. Family members in this policy refer to spouse, civil union partner, spousal equivalent, children, parents and parent-in-law, or any dependent living in the staff member's household. This policy is supplemental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

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.

Home Health & Hospice recognizes extenuating circumstance occur if an employee has a medical or family crisis that requires an extended absence.

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



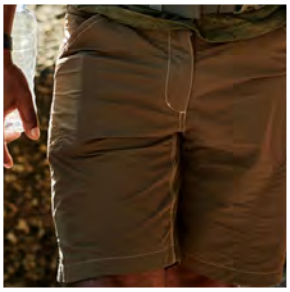
CTO Cash-In

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

YOU MAY ELECT TO HAVE YOUR CTO DIRECTED TO:

- Your 403(b) account
- Put into your paycheck
  - If you have your CTO transferred to your paycheck, you should be aware the value will be taxed at the supplemental rate, which is approximately 39.4%.
  - All employees who wish to cash-in CTO must obtain supervisor approval on the CTO Cash-In Request Form prior to cashing in CTO time. This form can be obtained from Human Resources (HR), you can email HR to request the form. The completed form can be returned to HR by email as well.

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



Incentive Combined Time Off (I-CTO)

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

FOR STAFF BENEFITED ON OR BEFORE JUNE 30, 2005	
Hours Worked Per Quarter	**Hours of Incentive CTO**
0-22.5	0
22.6-30	11.25
31-37.5	15
37.6+	18.75

I-CTO is calculated based on actual number of hours worked as follows:
I-CTO is calculated quarterly and is deposited into the employee's "bank" in the first pay period of October, January, April, and July.

QUALIFICATIONS TO USE TIME:

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

Tuition & Continuing Education

Tuition and Continuing Education Reimbursement is designed to help you with financial support to grow personally and professionally. Reimbursement is provided for undergraduate and graduate coursework as well as external continuing education opportunities. Funds are available through the Continuing Education Reimbursement Fund and the budget.

Tuition Reimbursement

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

Continuing Education

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

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

Conferences & Business-Related Activities

Employees may attend conferences or other business-related activities on behalf of the organization, or for professional development.

To be reimbursed for the cost of a conference or business-related travel; prior to the event you must complete the Conference and Business-Related Travel Expenses Approval Form. To be reimbursed, approval must be obtained before the expense is incurred.

If an employee is unable to pay for expenses in advance, they may ask their manager to request advanced payment of approved continuing education expenses. The employee is responsible for satisfactory completion of the course or program as outlined and submission of required forms.

If you have questions, contact your manager or Human Resources.

Reimbursement Process

To receive tuition reimbursement, employees must complete and submit a Tuition Reimbursement form 1-month before beginning a course or continuing education program. College Deferment of Payment forms will be accepted.

Employees should submit the form to their immediate manager. If approved, the manager will sign and submit the form to the program director or division director for approval.

Requests will be reviewed within two weeks. If approved, the manager will forward the request for tuition reimbursement to Human Resources for approval. Human Resources will communicate the approval or disapproval with the employee.

In order to receive tuition reimbursement, the following documents must be submitted to Human Resources:

- A Transcript (a copy of grades, continuing education documentation, certificate or letter of successful completion)
- Proof of payment for the actual cost of the college course

Reimbursement checks will be issued to the staff following receipt of all necessary documentation within the next Accounts Payable cycle.

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 FAMILY MEDICAL LEAVE

- Worked at UVMMC or any UVMHN Network Partner 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.

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**

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.

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 illness/injury 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/HHH 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. UVMHN/HHH 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 UVMHN/HHH, 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 UVMHN/HHH 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 UVMHN/HHH'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 UVMHN/HHH, 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/HHH 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

Home Health & Hospice 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 their family. Supervisors may approve bereavement time for family or other losses when appropriate. Any paid time off above three days requires the approval of the Supervisor in consultation with the Program Director.

EXTRAMURAL ACTIVITY LEAVE

Provides up to 2 weeks of leave per year to allow an employee to contribute their skills and knowledge in their profession, which could include teaching, lead institutes, and make studies that support the mission of the organization.

JURY DUTY

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

GENERAL ABSENCE WITHOUT PAY

An employee may request unpaid time off not to exceed two weeks. Requests are to be made to the employee's direct supervisor, in writing, as far in advance as possible.

EMERGENCY LEAVE

Up to six months unpaid leave in the event they are unable to work due to personal crisis that requires time off.

EDUCATIONAL LEAVE

Unpaid leave of absence for up to 12 months may be granted to an employee who has completed one (1) year of service to pursue educational opportunities that promote an employee's growth and development at Home Health & Hospice.

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 Director 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.

Other Leaves of Absence - Long Term

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

QUALIFICATIONS AND REQUIREMENTS NOTED ARE:

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

Affordable Care Act

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

THE ACA IS INTENDED TO:

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

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

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

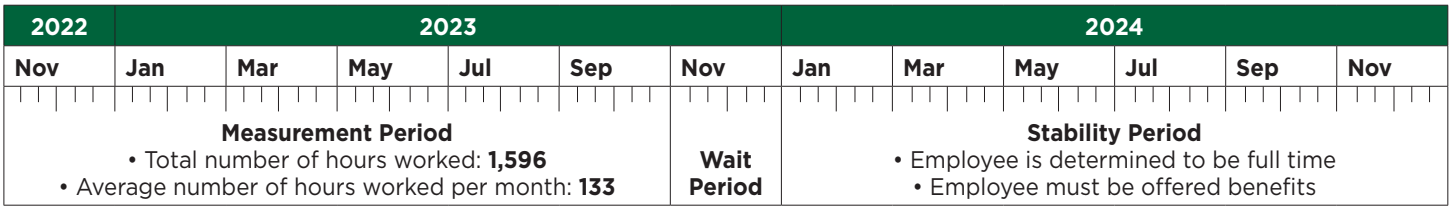
Employers are also required to report coverage information to the IRS and furnish covered individuals with a form that shows compliance with the individual shared responsibility provision of ACA. The annual notification, also known as the IRS Form 1095-C, must be sent annually to full-time employees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

UVM HEALTH NETWORK'S ACTION UNDER ACA

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

THERE ARE THREE METHODS FOR DETERMINING ELIGIBILITY UNDER THE ACA:

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



ACA-ELIGIBLE EMPLOYEE MEDICAL COVERAGE AT UVMHN

To comply with the ACA employer mandate, all ACA - eligible employees are offered the UVMHN HDHP 3200. The ACA Plan is a high deductible health plan that provides affordable minimum essential medical coverage (MEC) of minimum value (MV) to ACA eligible employees and their eligible dependents (spouse and children up to age 26).

NOTE: The ACA requires employers to offer minimum essential coverage (MEC) to ACA-eligible employees and their eligible dependent children up to age 26.

ACA-ELIGIBLE OPEN ENROLLMENT

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

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

HOW TO ENROLL

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

PAYING FOR COVERAGE

You are responsible for paying premiums each pay period. Premiums will be removed from your paycheck on a pre-tax basis if you work during the pay period.

If you do not work during the pay period, you will be billed for payment via personal check or credit card. All payments are due within 30 days. Failure to pay will result in cancellation of coverage.

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

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

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

IRS FORM 1095(C)

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

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

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

NOTE: UVMHN does not provide tax advice, please review with your tax advisor.

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

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides eligible covered employees and their dependents the opportunity to continue their health coverage after termination of employment, losing eligibility (i.e. divorce, children age 26) or moving to a non-benefits eligible role.

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

An initial notice is provided to all new employees upon enrollment in any health plans at UVMHN. This notice is to explain the COBRA law, our notification obligations and your potential rights under COBRA.

LOSING COVERAGE UNDER UVMHN PLANS

When you or a covered dependent lose eligibility to participate in UVMHN's health plans, the coverage will be terminated.

However, under most circumstances, you may continue the medical/prescription, dental, vision and health care flexible spending account benefits coverage through COBRA.

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

ENROLLING IN COBRA BENEFITS

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

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

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

COBRA Administrator: EBPA **CONTACT INFORMATION:** Phone (888) 232-3203	**PLANS AVAILABLE FOR CONTINUATION:** • **Medical** • **Dental** • **Vision** • **Health Care Flexible Spending Account** **PREMIUMS:** The full cost plus 2% administration fee is paid for by you. Premiums are paid directly to the EBPA

PAYING FOR COBRA

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

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

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

You cannot make other changes until the next open enrollment period, unless you experience a qualified life event.

If enrolled in an HDHP through COBRA, you will not receive the UVMHN contribution to your Health Savings Account (HSA).

Appendix – Additional Life Insurance Rates

Basic Life: Imputed Income Rates

ADDITIONAL LIFE INSURANCE RATES

BI-WEEKLY RATES ARE PER $1,000 OF COVERAGE	EMPLOYEE		SPOUSE	
	Term Life	Term Life With AD&D	Term Life	Term Life With AD&D
Age 29 and Under	0.026	0.046	0.040	0.080
30-34	0.034	0.054	0.052	0.092
35-39	0.039	0.059	0.058	0.098
40-44	0.046	0.066	0.069	0.109
45-49	0.069	0.089	0.104	0.144
50-54	0.121	0.141	0.179	0.219
55-59	0.199	0.219	0.294	0.334
60-64	0.340	0.360	0.501	0.541
65-69	0.661	0.681	0.973	1.013
70-74	1.263	1.283	1.860	1.900
Age 75 and Over	2.060	2.080	3.341	3.381
CHILD TERM LIFE	TERM LIFE WITHOUT AD&D		TERM LIFE WITH AD&D	
	0.0284		0.040	

CALCULATING LIFE INSURANCE PREMIUMS

You are electing $200,000 of additional coverage (with AD&D) and you are 34 years old **$200,000 / $1,000 = 200 x $0.054 = $10.80 (monthly)** Annual premium will be $129.60 or $4.98 bi-weekly

You are electing $250,000 of spouse life insurance **without AD&D** and your spouse is 33 years old **$250,000 / $1,000 = $250 x $0.052 = $13.00 (monthly)** Annual Premium will be $156.00 or $6.00 bi-weekly

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

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

You have $64,000 in term coverage

Imputed Income only applies to $14,000 – the amount of coverage above $50,000 Your age at the end of the calendar year

– 47 (Rate from Chart: $0.069)

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

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

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

2024 UVMHN HSA CONTRIBUTIONS

2024 UVMHN HSA Contributions	HDHP 1600		HDHP 3200	
Monthly Contribution	**Single**	**Family**	**Single**	**Family**
Jan	$266.50	$533.50	$533.50	$1,066.50
Feb	$24.23	$48.50	$48.50	$96.95
Mar	$24.23	$48.50	$48.50	$96.95
Apr	$24.23	$48.50	$48.50	$96.95
May	$24.23	$48.50	$48.50	$96.95
Jun	$24.23	$48.50	$48.50	$96.95
Jul	$24.23	$48.50	$48.50	$96.95
Aug	$24.23	$48.50	$48.50	$96.95
Sep	$24.23	$48.50	$48.50	$96.95
Oct	$24.23	$48.50	$48.50	$96.95
Nov	$24.23	$48.50	$48.50	$96.95
Dec	$24.23	$48.50	$48.50	$96.95
If your effective date is February - December, you will receive prorated amounts.				

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

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 1600 and HDHP 3200).

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 (250 and 400 plans).

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, costeffectiveness, 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-ofpocket 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

IMPORTANT INFORMATION AND REQUIRED NOTICES UNDER THE UNIVERSITY OF VERMONT HEALTH NETWORK EMPLOYEE WELFARE BENEFITS PLAN (THE "PLAN")

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 Health Network Employee Welfare Benefits Plan (the "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 The Human Resource Solution Center at (844) 777-0886 or email **HRSolutionCenter@UVMHealth.org**

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 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 o f 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:

https://hrportal.ehr.com/LinkClick.aspx?fileticket=O9QGMFfRoHA%3d&portalid=232

COVID 19 VACCINE DIAGNOSTIC TESTS

Blue Cross and Blue Shield: The COVID-19 vaccine is covered in full under the preventive benefits when using an in-network provider. If you receive the COVID-19 vaccine out-of-network you will be subject to out-of-network cost share, including the applicable deductible, coinsurance and co-pays. COVID-19 testing will be paid based on the plan you are enrolled in and those specific plan benefits including the applicable cost-share (deductible, coinsurance, co-pays). Over-the-counter COVID-19 test kits are not covered under the medical plan, however, they are covered under the pharmacy plan (see below).

Navitus: The COVID-19 vaccine is covered in full at participating pharmacies. If you receive the COVID-19 vaccine at a non-participating pharmacy, you will need to pay up front and submit a claim to Navitus for reimbursement. Over-the-counter COVID-19 test kits are covered in full at participating pharmacies, you can receive 8 tests/30 days. If you purchase test kits at a non-participating pharmacy, you will need to pay up front and submit a claim to Navitus for reimbursement.

WOMENS 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 m anner 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 the Human Resources Solutions Center at (844) 777-0886, (518) 562-7300 or email **HRSolutionCenter@UVMHealth.org** for more information about your rights under WHCRA. If you hav e 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 o f 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 faci lity 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 balanced 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 protec tions 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 abou t your rights under federal law.

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 TransparencyInCoverage | BlueCrossBlueShield of South Carolina (**myhealthtoolkitvt.com**).

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 University of Vermont Health Network 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 your employer for employment purposes (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 you are 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 or its affiliates 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 or any of its affiliates as participating employers 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 of an affiliate's employee or department, and (2) will not be used by UVMHN or your employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by your employer or 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 treat, 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:

The University of Vermont Health Network, Inc.
Privacy Officer
111 Colchester Ave.
Burlington, VT 05401-1473

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:

The University of Vermont Health Network, Inc.
Privacy Officer
111 Colchester Ave.
Burlington, VT 05401-1473

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:

The University of Vermont Health Network, Inc.
Privacy Officer
111 Colchester Ave.
Burlington, VT 05401-1473

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:

The University of Vermont Health Network, Inc.
Privacy Officer
111 Colchester Ave.
Burlington, VT 05401-1473

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 your employer without your authorization if the Plan Sponsor or your employer 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 the employer has provided health benefits under the Plan, and from which most identifying information has been deleted. The Plan may also disclose to the employer or 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:

The University of Vermont Health Network, Inc.
Privacy Officer
111 Colchester Ave.
Burlington, VT 05401-1473

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:

The University of Vermont Health Network, Inc.
Privacy Officer
111 Colchester Ave.
Burlington, VT 05401-1473

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, 2023.

IMPORTANT NOTICE FROM UVM HEALTH NETWORK 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 UVM Health Network (the "UVMHN 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. UVM Health Network- UVMHN has determined that the prescription drug coverage offered by the UVMHN Plan administered by Navitus Health Solutions is 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 are covered under the UVMHN 250 or 400 Plan and have a prescription, you must pay the pharmacy either an applicable Copayment or the cost of the drug, whichever isless, for each separate prescription or refill for that Prescription 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. Copayment amounts depend on the drug tier your prescriptionis filled with, whether you use a Participating Pharmacy and what option under the UVMHN Plan you elected, as shown in the chart below.

(2) If you are covered under one of the UVMHN HDHP with HSA options and have a prescription, you must first satisfy your plan deductible and after that, you would pay the pharmacy either an applicable Copayment or the cost of the drug, whichever is less, for each separate prescription or refill for that Prescription Drug. The pharmacy will be paid directly by the UVMHN Plan for the remainder of the cost of the prescription or the refill. The Copayment for Tier One Drugs does not apply to covered dependent children underage 19. Copayment amounts depend on the drug tier your prescription is filled with,whether you use a Participating Pharmacy and what option under the UVMHN Plan you elected, as shown in the chart below.

MEDICAL PLAN	UVMHN 250 & 400 Plan		UVMHN 1600 & 3200 HDHP with HSA	
Preventive Drugs	Covered as a co-pay based on formulary tier.		Certain Preventive Drugs are covered as a co-pay based on formulary tier.	
Pharmacy	Participating Pharmacy		Co-pays Apply After Deductible Participating Pharmacy	
UVMHN Retail/Mail Order	**30-Day Supply**	**90-Day Supply**	**30-Day Supply**	**90-Day Supply**
Tier 1	$0	$0	$0	$0
Tier 2	$25	$50	$25	$50
Tier 3	$45	$90	$45	$90
Navitus Retail Pharmacy				
Tier 1	$10	$30	$10	$30
Tier 2	$30	$90	$30	$90
Tier 3	$50	$120	$50	$120
Non-Participating Pharmacy				
All Tiers	Covered at 50%		Not Covered	

For purposes of determining the amount you must pay under Subparagraphs (1) and (2) 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: Non-participating pharmacies may charge you a higher price and you will be responsible for paying 50% of that price if you are covered by the UVMHN 250 or 400 Plan. The Plan will not pay for prescriptions filled at non-participating pharmacies if you are covered by the UVMHN 1500 or 3000 HDHP with HSA option.

Please refer to your Navitus 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 Navitus 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.

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: 10/1/2023

Contact: HR Solution Center at (844) 777-0886 or **HRSolutionCenter@UVMHealth.org**.

The University of Vermont Health Network, Inc.
111 Colchester Ave.
Burlington, VT 05401-1473

DISCRIMINATION IS AGAINST THE LAW

UVMHN and its affiliates comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UVMHN and its affiliates do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UVMHN and its affiliates:

Provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call 1-518-2000 x 5066

If you believe that any UVMHN Hospital or UVMHN Affiliate has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

UVMHN Benefits Department
University of Vermont Medical Center
UHC-151OH5
1 South Prospect St.
Burlington, VT 05401

The UVMHN Chief Compliance Officer, Jennifer Parks, is the point of contact for all grievances, whether filed by patients, employees, or others. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Jennifer Parks is available to help you. If you have a complaint or concern, you may contact her directly at (802) 847-8556 or via e-mail at **jennifer.parks@uvmhealth.org**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building,
Washington, DC 20201
1–800–368–1019, 800–537–7697(TDD).

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

Taglines

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-518-2000 x 5066.

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-518-2000 x 5066.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-518-2000 x 5066.

French Creole (Haitian Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-518-2000 x 5066.

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-518-2000 x 5066 번으로 전화해 주십시오.

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-518-2000 x 5066.

Yiddish
1- טפור לאצפא. זופ יירפ סעסיוורעס הליה דראפש דייא דראפ ראהראפ ואנעזע, שידיא ריא טדער ביוא :מאזקרעמפיוא . 1-518-2000 x 5066

Bengali
ল□য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পা◌েরন, তাহেল ি◌নঃখরচায় ভাষা সহায়তা পিরেষবা উপল□ আেছ। ◌েফান করন ১–1-518-2000 x 5066

Polish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-518-2000 x 5066.

Arabic
1-518-2000 x 5066ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-518-2000 x 5066.

Urdu
1-518-2000x5066. نیرک نیرک رادربخ: رگا پآ ودرا ےتلوب نیہ، وت پآ وک نابز یک ددم یک تامدخ تفم نیم بایتسد نیہ ۔ لاک

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-518-2000 x 5066.

Greek
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-518-2000 x 5066.

Alabanian
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-518-2000 x 5066.

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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: 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+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecover y.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-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	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)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – 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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/human-services/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program	Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badger-careplus/p-10095.htm Phone: 1-800-362-3002	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 July 31, 2023, 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 1/31/2026)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

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 employment-based 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 HR Solution Center 111 Colchester Avenue, Burlington, VT 05401; HRSolutionCenter@uvmhealth.org; 844-777-0886

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **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.

Notes

THE
University of Vermont
HEALTH NETWORK

Home Health & Hospice

2024