

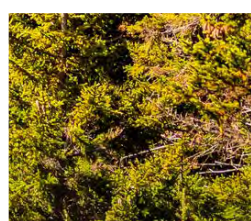
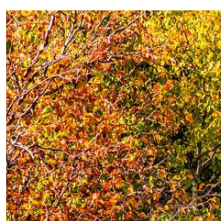
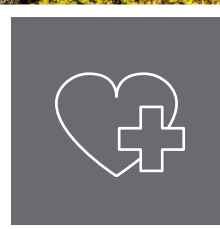
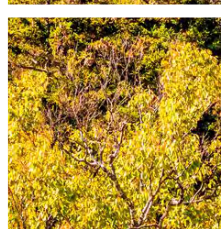
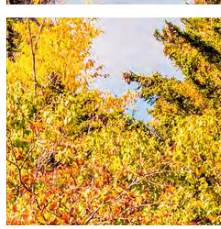
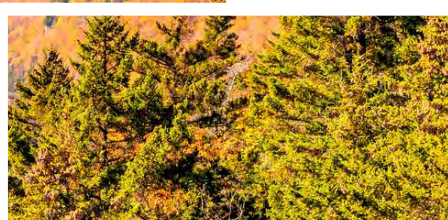
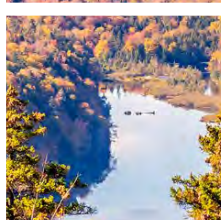
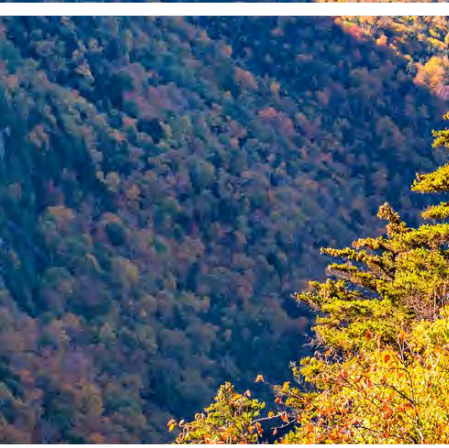
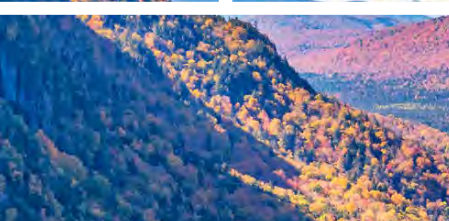
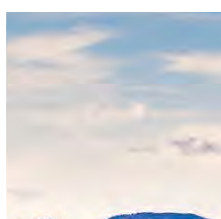
THE
University of Vermont
HEALTH NETWORK

Alice Hyde Medical Center

BENEFITS GUIDEBOOK

SEIU S&M/Tech

2025





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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Each section is hyperlinked, click on the section name/page number and go to that section/page. Underlined items within the guidebook are hyperlinked.

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

Open Enrollment: Take Action!

November 4 - November 15, 2024

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) in 2025. Spending Accounts **do not automatically rollover**.

All enrollments and changes will be effective January 1, 2025. If you do not make any changes, your benefits will automatically rollover to 2025, **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
SEIU	P: 315-218-6513 F: 315-701-0686	khale@sebf.org	www.1199SEIU.org
Payroll: Gail Laflesh	518-481-2616	glaflesh@alicehyde.com	
Local HR	P: 518-481-2268 F: 518-481-2598	ahmchrdept@alicehyde.com	
Occupational Health & Wellness (OHW)	518-481-2415	AHMCochealth@alicehyde.com	Occupational Health & Wellness

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
SEFB Medical	Excellus BlueCross BlueShield		1-877-650-5840	www.excellusbcbcs.com/sebf
Flexible Spending Accounts (FSAs)	HSA Bank	UVH726	855-731-5218	https://www.hsabank.com/hsabank/homepage
Dental	Northeast Delta Dental	7407	800-832-5700	nedelta.com
SEFB Dental	Service Employees Benefit Fund		(855) 835-9720	www.sebf.org
Vision	Vision Service Plan	12157661	800-877-7195	vsp.com
SEFT Vision	DavisVision	6913	1-800-999-5431	Davisvision.com
Short-Term Disability (STD) Long-Term Disability (LTD) Life Insurance	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/uvmhhealthnetwork
Pet Insurance	Nationwide	UVM Health Network	Enrollments 877-738-7874 Customer Care 800-540-2016	benefits.petinsurance.com
Employee Assistance Program	Lyra		888-632-3189 (US) or 800-874-3817 (Canada)	uvmhn.lyrahealth.com

Eligibility

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

- **Full-Time Regular:** Hired to regularly work 36+ hours
- **Part-Time Regular:** Hired to regularly work 16-35 hours (all benefits except Basic Life)

ENROLLMENT OPT-OUT PROGRAM

You must complete the AHMC Opt-Out Enrollment Form for 2025 if you want to participate in the opt-out program.

WHEN DOES MY COVERAGE START?

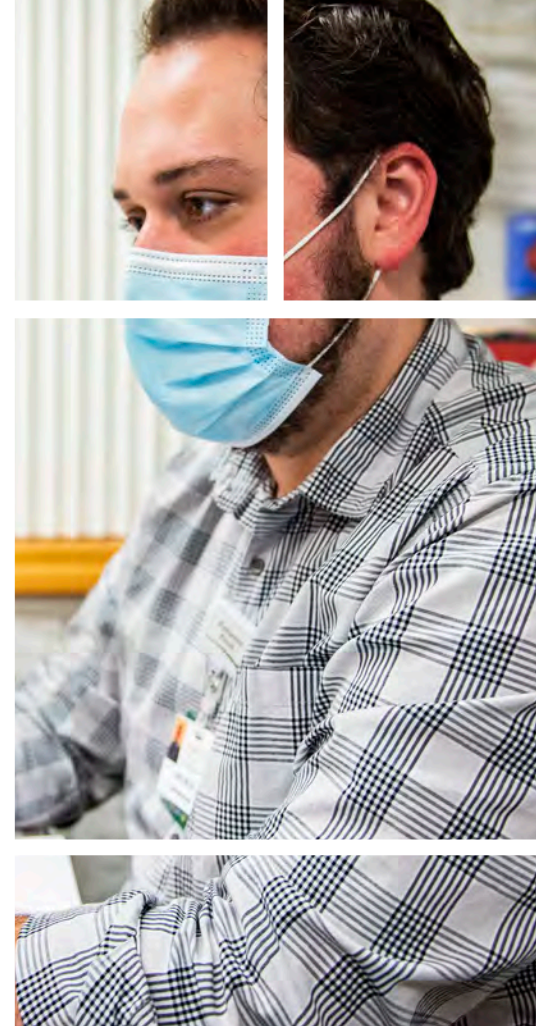
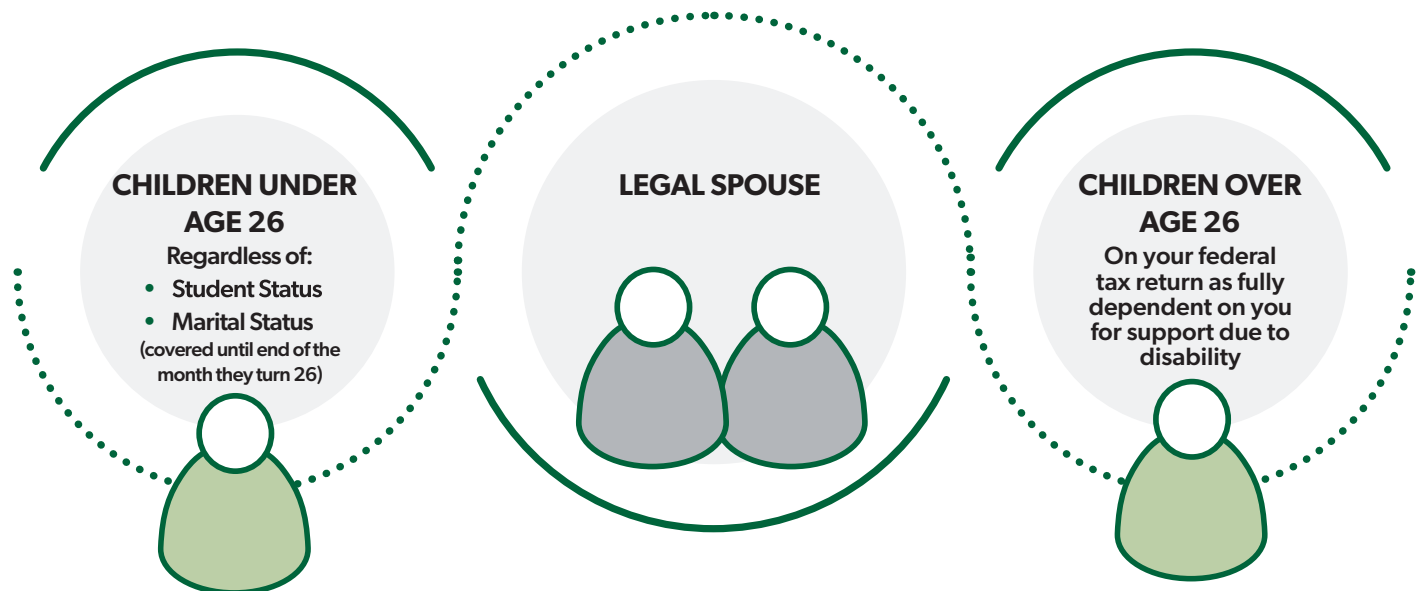
Coverage begins the first of the month following your date of hire or any change that makes you benefits-eligible. If your date of hire or benefits eligibility date is the first day of the month, your benefits begin that day.

EXAMPLE:

- **Hire Date:** January 6
- **Time to Enroll in Coverage:** January 6 - February 5 (31 days)
- **Coverage Starts:** February 1

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

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



Eligible Dependents – Dependent Verification

If you enroll your dependent(s), UVMHN requires you to provide documents to verify your dependents eligibility. The below chart lists the dependent verification documents required for each eligible dependent. You can scan and upload the dependent verification documents to [Workday](#) or 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 the 31 day benefits election window. Failure to provide documentation will result in your dependent being ineligible for coverage.

OPEN ENROLLMENT

Dependent verification documents must be provided before the beginning of the calendar year. Failure to provide documentation will result in your dependent being ineligible for coverage.

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.

PAYING FOR COVERAGE

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

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	<ul style="list-style-type: none"> Employee Spouse Eligible Dependent(s) 	Elections/Changes must be made by the last day of Open Enrollment.	January 1	OE Period: 11/4 - 11/15 Coverage starts 1/1
Loss of Coverage/ Eligibility Under Another Group Plan	<ul style="list-style-type: none"> Employment Change Divorce/ Annulment/Legal Separation Death of Spouse Child under age 26 loses coverage Child loses coverage due to turning age 26 allows them to enroll in their own coverage, if applicable through their spouse, employer, the health care exchange or state/federal programs 	<ul style="list-style-type: none"> Employee Spouse Dependent(s) 	31 days 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Birth of Child Adoption or Placement for Adoption Legal Guardianship Appointment 	<ul style="list-style-type: none"> 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
<p>IMPORTANT REMINDER - Adding Newborn to UVMHN Medical Plan:</p> <p>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.</p> <p>If you do not contact the HR Solution Center within 60 days from the date of birth, your newborn will not be added to your medical plan. If your newborn is not be added to your medical plan, you will have the option to purchase COBRA coverage for 102% of the premium or find other coverage. You must contact the HR Solution Center to start the COBRA process. 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.</p>					
Loss of Coverage Medicaid Children's Health Insurance Program (CHIP)	Medicaid or CHIP coverage terminates	<ul style="list-style-type: none"> Employee Eligible Dependent(s) 	60 days 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	<ul style="list-style-type: none"> 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 the **31 day benefits election window**. (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 the **31 day benefits election window** (see page 6). **IMPORTANT: Failure to provide documentation will result in your dependent being ineligible for coverage.**

6. VIEW YOUR PAYSALIP

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.

- **Email:** glaflesh@alicehyde.com
- **Phone:** 518-481-2616

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.



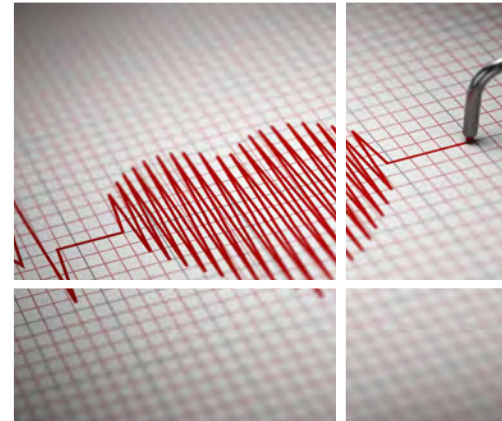
Medical

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

The UVMHN 400 plan has three tiers of coverage:

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



EMBEDDED DEDUCTIBLE

The **UVMHN 400** plan has an embedded family deductible. The plan begins to pay when one member of the family reaches their individual deductible.

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 (UVMHN facilities/providers) and Tier 2/In-Network providers.

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

Service Employees Benefit Fund (SEBF)

2024 Benefit Year



Excellus BluePPO Benefits

Type of Care/Plan Benefits	In-Network	Out-Of-Network
BluePPO Plan Features		
Primary Care Physician (PCP)	Not required	
Referrals	Not required	
Pre-Certification	Required for all inpatient admissions (excluding maternity). Provider notification is required for certain Medical Specialty Drug (MSD) and certain Behavioral Health Services. Includes Home Health Care, Infusion Therapy, Durable Medical Equipment over \$200, MRI, CAT Scans and PET Scans	
Pre-Certification Penalty	No Penalty for In-Network Providers	\$400 Penalty, Per Occurrence
Out of network benefits	Covered, unless noted. Please note: The amount the plan pays for covered services is based on an allowed amount. If an out of network provider charges more than the allowed amount, you will have to pay the difference between the actual charge and the allowed amount.	
Out of area benefits	Coverage provided worldwide through the BlueCard® program	
Dependent coverage	Qualified dependents covered to age 26 (end of month)	
Domestic partner	Covered (if eligible)	
Coverage Period	January 1st - December 31st	
Plan cost-sharing highlights		
Telemedicine visit with MDLIVE	FREE VISIT - \$0 Copay Register online at ExcellusBCBS.com/Telemedicine or download the MDLIVE App.	No Coverage
Office visit copay (Includes Telehealth visits) Primary Care Physician	\$40 Copayment	Covered at 70% of allowance, subject to the deductible
Office visit copay (Includes Telehealth visits) Specialist	\$40 Copayment	Covered at 70% of allowance, subject to the deductible
Coinsurance	0%, unless noted	30% of allowance, unless noted
Deductible	None	\$1,000 Individual \$2,000 Family
Out-of-Pocket Maximum (Medical Only. RX has a separate Out-of-Pocket Maximum)	\$5,150 Individual \$7,900 Family	None
Inpatient Hospital/Facility Copayment	\$500 Per Admission Limit: \$1,500 maximum copayment, per person, per calendar year	Covered at 70% of allowance, subject to the deductible. Precertification applies
Lifetime maximum	None	

Service Employees Benefit Fund (SEBF)

2024 Benefit Year



Excellus BluePPO Benefits

Type of Care/Plan Benefits	In-Network	Out-Of-Network
Wellness Incentives		
Stay healthy with great programs and incentives!	Blue365 - Take advantage of exclusive discounts on health and wellness products and services, including fitness, exercise, nutrition, elective procedures and hearing aids. For additional information on Blue365 , please visit: www.excellusbcbs.com/sebf	
Preventive Health Care Services*		
Well child visits	Covered in Full	Covered at 100% of allowance, subject to the deductible
Adult routine physical exam	Covered in Full	Covered at 100% of allowance, subject to the deductible
Adult immunizations	Covered in Full	Covered at 100% of allowance, subject to the deductible
Mammography	Covered in Full	Covered at 70% of allowance, subject to the deductible
Pap smear	Covered in Full	Covered at 70% of allowance, subject to the deductible
Routine GYN exam	Covered in Full	Covered at 70% of allowance, subject to the deductible
Prostate cancer screening	Covered in Full	Covered at 70% of allowance, subject to the deductible
Colonoscopy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Physician Office Services		
Telemedicine visit with MDLIVE	FREE VISIT - \$0 Copay Register online at ExcellusBCBS.com/Telemedicine or download the MDLIVE App.	No Coverage
Diagnostic office visits (Includes Telehealth visits)	\$40 Copayment	Covered at 70% of allowance, subject to the deductible
Surgery	\$40 Copayment	Covered at 70% of allowance, subject to the deductible
Advanced Imaging Services (Includes PET Scans, CAT Scans, MRI's and Nuclear Medicine)	\$75 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Diagnostic X-Rays	Covered in Full	Covered at 70% of allowance, subject to the deductible
Diagnostic laboratory and pathology	Covered in Full	Covered at 70% of allowance, subject to the deductible

Service Employees Benefit Fund (SEBF)

2024 Benefit Year



Excellus BluePPO Benefits

Type of Care/Plan Benefits	In-Network	Out-Of-Network
Allergy testing	\$40 Copayment	Covered at 70% of allowance, subject to the deductible
Allergy treatment including serum	Covered in Full	Covered at 70% of allowance, subject to the deductible
Chemotherapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Radiation therapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Infusion therapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Maternity Services		
Prenatal Care	Covered in Full	Covered at 70% of allowance, subject to the deductible
Hospital care for mom (including delivery)	\$500 Copayment then Covered in Full	Covered at 70% of allowance, subject to the deductible
Newborn nursery care	Covered in Full	Covered at 70% of allowance, subject to the deductible
Inpatient Hospital Benefits		
Hospital benefits	\$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Physician visits in the hospital	Covered in Full	Covered at 70% of allowance, subject to the deductible
Inpatient physical rehabilitation	\$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Limit: 60 days per calendar year. Precertification applies
Surgery (Professional charge)	Covered in Full	Covered at 70% of allowance, subject to the deductible
Anesthesia	Covered in Full	Covered at 70% of allowance, subject to the deductible
Emergency Care		
Emergency room care	No Coverage for Non-Emergency Care \$100 Copayment per visit then Covered in Full (Copayment waived if admitted inpatient)	No Coverage for Non-Emergency Care \$100 Copayment per visit then Covered at 100% of allowance (Copayment waived if admitted inpatient)
Freestanding urgent care center	\$40 Copayment	Covered at 70% of allowance, subject to the deductible

Service Employees Benefit Fund (SEBF)

2024 Benefit Year



Excellus BluePPO Benefits

Type of Care/Plan Benefits	In-Network	Out-Of-Network
Observation stay	\$100 Copayment per visit then Covered in Full (Copayment waived if admitted inpatient)	Covered at 70% of allowance, subject to the deductible
Ambulance (Ground or Air)	\$50 Copayment then Covered in Full	\$50 Copayment then Covered at 100% of allowance
Outpatient Hospital Benefits		
Advanced Imaging Services (Includes PET Scans, CAT Scans, MRI's and Nuclear Medicine)	\$75 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Diagnostic X-Rays	Covered in Full	Covered at 70% of allowance, subject to the deductible
Diagnostic laboratory and pathology	Covered in Full	Covered at 70% of allowance, subject to the deductible
Surgical care (Facility Fee: Includes Ambulatory Surgery Center)	\$75 Copayment then Covered in Full	Covered at 70% of allowance, subject to the deductible
Chemotherapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Radiation therapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Mental Health and Chemical Dependence		
Inpatient mental health care	\$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Outpatient mental health care	\$40 Copayment	Covered at 70% of allowance, subject to the deductible
Inpatient chemical dependence	\$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Outpatient chemical dependence	\$40 Copayment	Covered at 70% of allowance, subject to the deductible
Other Services		
Skilled nursing facility	\$500 Copayment then Covered in Full. Limit: 60 visits per calendar year. Limits are combined INN and OON. Precertification applies	Covered at 70% of allowance, subject to the deductible. Limit: 60 visits per calendar year. Limit are combined INN and OON. Precertification applies
Home care	\$40 Copayment Limit: Total of 40 visits per calendar. Limits are combined INN and OON. Precertification applies	Covered at 75% of allowance, subject to deductible. Limit: Total of 40 visits per calendar. Limits are combined INN and OON. Precertification applies
Hospice	\$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies.

Service Employees Benefit Fund (SEBF)

2024 Benefit Year



Excellus BluePPO Benefits

Type of Care/Plan Benefits	In-Network	Out-Of-Network
Infusion Therapy (Facility Charge)	\$40 Copayment Precertification applies	Covered at 75% of allowance, subject to the deductible. Precertification applies
Outpatient therapy (Physical and Occupational)	\$40 Copayment Limit: Combined total of 60 visits per calendar. Includes aggregate of visits for INN and OON and professional and facility covered services.	Covered at 70% of allowance, subject to the deductible. Limit: Combined total of 60 visits per calendar. Includes aggregate of visits for INN and OON and professional and facility covered services.
Outpatient therapy (Speech)	\$40 Copayment Limit: Total of 20 visits per calendar. Includes aggregate of visits for INN and OON and professional and facility covered services.	Covered at 70% of allowance, subject to the deductible. Limit: Total of 20 visits per calendar. Includes aggregate of visits for INN and OON and professional and facility covered services.
Cardiac & Pulmonary Rehabilitation	\$40 Copayment	Covered at 70% of allowance, subject to the deductible
Diabetic insulin and supplies	Covered only through your Prescription Drug Plan with Express Scripts.	Covered only through your Prescription Drug Plan with Express Scripts.
Durable medical equipment	Covered at 80% Precertification applies if over \$200	Covered at 70% of allowance, subject to the deductible. Precertification applies if over \$200
External prosthetics	Covered in Full	Covered at 70% of allowance, subject to the deductible
Chiropractic	\$40 Copayment Limit: 20 visits per calendar year. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible Limit: 20 visits per calendar year. INN & OON limits are combined
Acupuncture	\$40 Copayment Limit: 20 visits per calendar year. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible Limit: 20 visits per calendar year. INN & OON limits are combined
Infertility Services	Covered same as similar services under the benefit plan. Limits: Artificial Insemination: 4 cycles per lifetime. IVF: 1-cycle per lifetime. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible Limits: Artificial Insemination: 4 cycles per lifetime. IVF: 1-cycle per lifetime. INN & OON limits are combined
Routine Hearing Exam	\$40 Copayment Limit: 1 exam every 24 months. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible. Limit: 1 exam every 24 months. INN & OON limits are combined
Hearing Aids	\$40 Copayment Limit: \$2,500 maximum per 12 months. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible. Limit: \$2,500 maximum per 12 months. INN & OON limits are combined
Accidental Dental	Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly.	Covered at 70% of allowance, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly.

Service Employees Benefit Fund (SEBF)

2024 Benefit Year



Excellus BluePPO Benefits

Type of Care/Plan Benefits	In-Network	Out-Of-Network
<p>Prescription Drug Coverage</p>	<p>See pages 7 and 8 for Prescription Drug Coverage.</p>	
<p>Smoking Cessation (42 day program)</p>	<p><u>This FREE Quit Smoking Program through Wellframe® includes:</u></p> <p>The Wellframe® App connects you to Care Managers to provide confidential, text-based, one-on-one outreach using a smartphone or tablet. You will receive guidance, support and a personalized care plan to help you Quit Smoking.</p> <p>HOW CAN I GET STARTED?</p> <p>Visit wellframe.com/download on your smartphone or tablet to install the Wellframe app. Download the Wellframe app and select Create New Account. Your access code is: EXCELLUS</p>	
<p>Excellus BlueCross BlueShield Customer Care: 1-877-650-5840 www.excellusbcbs.com/sebf</p>		

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. These benefits should not be interpreted as pre-approval of services. Payment of claims related to these benefits are subject to the member's eligibility on the date of service and the resolution of any other outstanding claims. The member is responsible for payment of a copay, deductible, coinsurance or any combination based on plan design.

*Preventive Services are not subject to Cost-Sharing when performed by a Participating Provider and provided in accordance with the comprehensive guidelines (including age and visit guidelines) supported by the Health Resources and Services Administration (HSRA) or if the items or services have a "A" or "B" rating from the United States Preventive Services Task Force (USPSTF), or the immunizations are recommended by the Advisory Committee on Immunization Practices (ACIP).

Service Employees Benefit Fund (SEBF)

2024 Benefit Year



Excellus BluePPO Benefits

Type of Care/Plan Benefits	In-Network	Out-Of-Network
Prescription Drug Benefits		

There is no deductible.

You pay 30% coinsurance for Generic, Brand and Specialty Drugs.

You pay 50% coinsurance for Proton Pump Inhibitors (heartburn medications) and Antihistamines (allergy medications). There are over the counter alternatives available.

Diabetic Programs:

Patient Assurance Program

Participants will pay no more than \$25 per 30 days for eligible Type 2 diabetic drugs for retail and mail order. Up to \$50 is provided by manufacturer assistance. This assistance is applied at the point of sale. Please note that manufacturer assistance will not be applied to your out-of-pocket maximum under this Plan.

Insulin Out-of-Pocket Maximum

Participants will not be required to pay more than \$100 out-of-pocket for a 30-day supply of a covered prescription insulin drug.

Birth Control is covered at 100%, however, brand name birth control will be subject to coinsurance, unless a physician indicates medical necessity.

You are required to use the mail order for maintenance/long term medications after the third fill at a retail pharmacy or you will be responsible for 100% of the cost of the medication.

Advanced Opioid Management Program – supply limits, prior authorizations and review may be necessary for certain opioid prescriptions.

Generic Advantage Program (GAP): If you choose a brand-name medication when a generic equivalent is available, you will pay the coinsurance amount, plus the difference between the brand-name cost and the generic cost. The difference that you pay between the brand name cost and the generic cost is not applied to your out-of-pocket maximum.

The Plan has limits on the amount you will pay per calendar year for prescription drugs. The out-of-pocket maximum is the total amount you will have to pay in a calendar year related to covered prescription drug expenses.

Prescription Out-of-Pocket Maximum is:

Individual - \$1,200 per calendar year

Family - \$4,800 per calendar year

Once you satisfy the out-of-pocket maximum, all subsequent covered prescriptions will be paid by the Plan at 100% for the rest of that calendar year. Out-of-Network prescription costs do not apply to the out-of-pocket maximum.

Service Employees Benefit Fund (SEBF)

2024 Benefit Year



Excellus BluePPO Benefits

Type of Care/Plan Benefits	In-Network	Out-Of-Network
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If you use a non-participating pharmacy, you pay in full and submit a claim to Excellus to reimburse you at the negotiated cost. Reimbursement will be the amount that would have been charged by the participating pharmacy less your applicable coinsurance.

To find a Participating Retail Pharmacy or view a copy of the National Preferred Formulary, visit www.excellusbcbcs.com/sebf.

Retail Pharmacy Benefits

You can get up to a **30-day supply** at the Retail Pharmacy for short-term medications.

Mail Order Pharmacy Benefits

You can get up to a **60-day supply** of maintenance medication through mail order.

Maintenance medications are drugs that you take on a long-term basis for conditions such as high cholesterol, diabetes and asthma. Controlled substances are not subject to the mandatory mail order rule.

You may fill a maintenance/long-term medication up to three times at your local participating retail pharmacy. Beginning with the fourth fill, you must fill the prescription through the Express Scripts or Wegmans Mail Order.

If you choose to purchase your maintenance medications at a retail pharmacy after the third fill, you will be responsible for 100% of the cost of the medication.

You can use Express Scripts (www.express-scripts.com or call 1-855-315-5220) or Wegmans Mail Order (1-800-586-6910) to get up to a 60-day supply of maintenance medications.

Specialty Pharmacy Benefits (Accredo)

Specialty medications are prescribed for conditions that are difficult to treat with traditional medications like multiple sclerosis, rheumatoid arthritis, hepatitis C and others. These medications are self-administered, either taken orally or by injection. Specialty pharmacies are experts in handling and administering these complex medications.

Note: If you use a Specialty Pharmacy other than Accredo, you will be responsible for the full cost of the prescription. If your Specialty drug qualifies for the SavonSP Program, you must confirm enrollment in the SavonSP Program. Specialty drug cost sharing under the SavonSP Program does not count towards the out-of-pocket maximum.

Prior authorization is required for prescription drugs designated as “specialty” medications by Excellus BCBS and administered by a healthcare professional in clinics, hospitals or providers offices.

If you have questions regarding Accredo, please call Accredo directly at (800) 922-8297 or call Excellus Customer Care at (877) 650-5840.

If you have any questions regarding your SEBF Prescription Drug benefits, please call Excellus BlueCross BlueShield at (877) 650-5840.

Prescription Drug Plans

Prescription drug coverage is included with the UVMHN 400 plan medical plan. Medical and prescription drug coverage cannot be purchased separately. Navitus administers our prescription drug plan, you will receive a separate ID card from Navitus.

400 PLAN		
Preventive Drugs	Covered as a copay based on formulary tier	
Pharmacy	Network Pharmacy	
UVMHN Retail/ Mail Order	30-Day Supply	90-Day Supply
Tier 1	\$0	\$0
Tier 2	\$25	\$50
Tier 3	\$45	\$90
Navitus Network - Retail Pharmacy		
Tier 1	\$10	\$30
Tier 2	\$30	\$90
Tier 3	\$50	\$150
Non-Participating Pharmacy		
All Tiers	Covered at 50%	



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



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.

Flexible Spending Accounts (FSAs)

HSA Bank will replace Health Equity and become the new administrator of your Flexible Spending Account (FSA) beginning January 1, 2025. **Health Equity debit cards expire December 31, 2024.**

2024 Health Care FSA claims and/or 1/1/24 - 3/15/25 Dependent Care FSA claims must be submitted to Health Equity by May 31, 2025. Unused Health Care FSA funds up to the \$640 maximum may be rolled over to HSA Bank. Unused Dependent Care FSA funds will be forfeited.

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 [HSA Bank](#) 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 \$3,200 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 1650 & 3300 plans can contribute up to \$3,200 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.

REMINDER: USE IT OR LOSE IT

You have until May 31, 2026 to submit expenses for 2025. Any funds greater than \$640 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 \$640 of unused funds into the next plan year. The carryover amount doesn't count towards your annual contribution maximum. Any unused funds greater than \$640 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 2025 Health Care FSA and spend \$1,000 by December 31, 2025 you will have until May 31, 2026 to file 2025 expenses. If you do not have \$360 in expenses from 2025 to claim for reimbursement, you will forfeit the \$360 and \$640 will carry over to the 2026 plan year.



Using Your FSA Money

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

- **Pay by Debit Card:** Available for HSA, Health Care FSA, Limited Purpose FSA, and Dependent Care FSA (if the dependent care provider accepts debit cards).
- **Reimburse Yourself:** If you have paid for an eligible expense out of pocket, you can link an external bank account and transfer funds to reimburse yourself. For HSA, you can reimburse yourself for out of pocket expenses even years after you have paid out of pocket! HSA Bank will store your receipts digitally; simply take a picture of your receipt and upload via the HSA Bank Mobile App.
- **Online Bill Pay:** Access your account to pay your provider of service 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. HSA Bank 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, 2026 to incur expenses that can be paid for using funds remaining from the 2025 plan year.

EXAMPLE: If you have \$300 remaining at the end of the plan year (December 31, 2025), those funds will remain available for you to use for eligible expenses until March 15, 2026. You have until May 31, 2026 to submit those 2025 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 earn more than \$155,000 in compensation for the 2024 tax year.

Medical Rates

AHMC Full-Time (36+ hours weekly)

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST	ANNUAL COST (YOU + UVMHN)
Medical				
Premier 400	Your Cost	UVMHN		
1 Person	\$44.79	\$374.15	\$1,165	\$10,892
2 Person	\$266.74	\$571.37	\$6,935	\$21,791
Family	\$363.94	\$746.43	\$9,462	\$28,870
SEIU S&M/Tech	Your Cost	UVMHN		
1 Person	\$0.00	\$484.31	\$484	\$1,049
Family	\$224.36	\$897.40	\$1,122	\$2,430

AHMC Part-Time (16-35 hours weekly)

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST	ANNUAL COST (YOU + UVMHN)
Medical				
Premier 400	Your Cost	UVMHN		
1 Person	\$89.99	\$328.95	\$2,340	\$10,892
2 Person	\$530.98	\$307.13	\$13,805	\$21,791
Family	\$854.64	\$255.73	\$22,221	\$28,870
SEIU S&M/Tech	Your Cost	UVMHN		
1 Person	\$96.87	\$387.44	\$484	\$1,049
Family	\$734.31	\$387.44	\$1,122	\$2,430

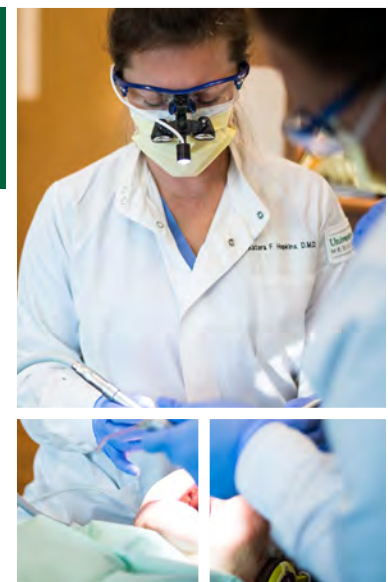
Dental



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!



Delta Dental Rates

Full-Time (36+ Hours Weekly)

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST
Dental			
Basic	Your Cost	UVMHN	
1 Person	\$17.43	\$0.00	\$453
2 Person	\$31.61	\$0.00	\$822
Family	\$57.55	\$0.00	\$1,496
Core	Your Cost	UVMHN	
1 Person	\$20.03	\$0.00	\$521
2 Person	\$36.33	\$0.00	\$945
Family	\$66.14	\$0.00	\$1,720
Buy-up	Your Cost	UVMHN	
1 Person	\$21.42	\$0.00	\$557
2 Person	\$39.12	\$0.00	\$1,017
Family	\$71.27	\$0.00	\$1,853

Part-Time (16-35 Hours Weekly)

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST
Dental			
Basic	Your Cost	UVMHN	
1 Person	\$17.43	\$0.00	\$453
2 Person	\$31.61	\$0.00	\$822
Family	\$57.55	\$0.00	\$1,496
Core	Your Cost	UVMHN	
1 Person	\$20.03	\$0.00	\$521
2 Person	\$36.33	\$0.00	\$945
Family	\$66.14	\$0.00	\$1,720
Buy-up	Your Cost	UVMHN	
1 Person	\$21.42	\$0.00	\$557
2 Person	\$39.12	\$0.00	\$1,017
Family	\$71.27	\$0.00	\$1,853



Service Employees Benefit Fund (SEBF) Dental Plans

Service Employees Benefit Fund (SEBF) offers you and your eligible dependents dental coverage based on a fixed reimbursement schedule with **no Deductibles and a Maximum Benefit of \$1,500 per person, per calendar year.**

SEBF pays 100% of the fixed dollar amounts as outlined on the Dental Schedule of Benefits, subject to the maximum benefit of \$1,500 per person, per calendar year.

There are three dental plans available. For more information, please refer to your collective bargaining agreement for specific details or contact SEBF to determine what you and your dependents are eligible for.

Basic Plan

The Basic Plan includes:

Two Exams, Two Cleanings Per Year, X-rays, Fillings, Extractions, Periodontics (gums) and Endodontics (root canals)

Comprehensive Plan

The Comprehensive Plan includes everything listed under the Basic Dental Plan *plus* the following procedures:

Prosthetics: Crowns, Bridgework, Partial and Full Dentures

Comprehensive with Orthodontia Plan

Includes the Comprehensive Plan *plus* coverage for Orthodontic treatment with a lifetime maximum benefit of \$1,500 for **eligible dependent children up to age 19.**

You can choose any licensed dentist. However, it is to your advantage to choose a Participating Dentist.

If you choose a Participating Dentist:

- Dentist will file your claim(s) with SEBF;
- SEBF will send payment directly to the participating dentist; and

- Dentist agrees to accept the SEBF payment as payment in full for covered services; subject to the maximum benefit of \$1,500 per person, per calendar year.

If you choose a Non-participating Dentist:

- You will be responsible for submitting an itemized bill to SEBF if the dentist doesn't;
- Payment will be made directly to you unless you assign the payment to your dentist. If you authorize the assignment, you are giving SEBF permission to pay the dentist directly instead of sending payment directly to you; and
- Reimbursement will be made according to the SEBF Dental Schedule of Benefits. **You will be responsible for paying the difference between your dentist's charge and SEBF's payment, if any.**

Pre-Treatment Estimate

A pre-treatment estimate is when your dental provider submits a treatment plan to SEBF for an estimate of what services will be covered and what SEBF will pay towards those services as well as what the patient's out of pocket will be. This is especially useful for more costly procedures such as crowns, extractions, dentures and periodontal surgery.

A pre-treatment estimate is not a guarantee of payment. When the services are complete and a claim is received for payment, SEBF will calculate its payment based on your current eligibility and amount remaining in your \$1,500 calendar year maximum.

Plan Limitations

- Exams - two per calendar year
- Cleanings - two per calendar year
- Bitewing X-rays - four every 12 months
- Full Mouth or Panorex X-ray - one every three years
- Fluoride for children covered up to age 19



(SEBF) Dental Plans

- Sealants for children covered up to age 14
- Periodontal Scaling - two quadrants per visit
- Prosthetics—crowns, bridgework, partial/full dentures are limited to five-year replacement

*Please contact SEBF to verify that your employer allows domestic partner coverage.

Please contact SEBF or visit our website at www.sebf.org if you need:

Plan Exclusions

- Cosmetic services
- Bleaching
- Implants
- Oral Hygiene Instruction
- Infection Control
- Temporary Prosthetics
- Adult Fluoride

- A copy of the Dental Schedule of Benefits (most commonly used procedures)
- A copy of the Dental Schedule of Benefits - complete schedule
- A list of the SEBF Participating Dentists
- Domestic partner application
- More information regarding your dental coverage

Who's Covered?

If you are enrolled for Individual plus One Dependent or Family coverage, SEBF offers benefits for legal spouse, domestic partner* (may be different sex or same sex and you must meet certain requirements) and dependent children. Dependent children will be covered until the 1st day of the month following their 26th birthday.

Service Employees Benefit Fund Representatives are available

Monday through Friday from 8:00 a.m. - 4:00 p.m.

(315) 218-6513

(855) 835-9720 Toll free

(315) 701-0686 Fax

www.sebf.org

Full-Time

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST
SEIU Dental			
Tier	Your Cost	UVMHN	
Employee Only	\$0.00	\$17.61	\$0.00
Employee + 1	\$5.37	\$21.49	\$140
Family	\$7.45	\$29.79	\$194

Part-Time

PLAN	BI-WEEKLY PRE-TAX COST SHARE		YOUR ANNUAL COST
SEIU DENTAL			
Tier	Your Cost	UVMHN	
Employee Only	\$3.52	\$14.09	\$91
Employee +1	\$12.78	\$14.09	\$332
Family	\$23.15	\$14.09	\$602



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.

NOTE: Many Costco providers are part of the **VSP** network. Call your local Costco to determine if their providers are in or out of network.

	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%

VSP Vision Rates

Full-Time/Part-Time

PLAN	BI-WEEKLY PRE-TAX COST SHARE		ANNUAL COST	
Vision				
Core	Your Cost	UVMHN		
1 Person	\$2.29	\$0.00	\$60	\$60
2 Person	\$4.59	\$0.00	\$119	\$119
Family	\$7.39	\$0.00	\$192	\$192
Buy-up	Your Cost	UVMHN		
1 Person	\$3.77	\$0.00	\$98	\$98
2 Person	\$7.55	\$0.00	\$196	\$196
Family	\$11.77	\$0.00	\$306	\$306



Service Employees Benefit Fund (SEBF) Vision Plan

Welcome to Davis Vision!

We are pleased to provide you with information on your vision benefit to help you care for your vision and eye health - a key part of overall health and wellness!

If you are not currently enrolled, please visit our member site at davisvision.com or call 1.877.923.2847 and enter client code 6913 to locate providers or for additional information.

Your Davis Vision Designer Plan Benefits

Davis Vision

Using your benefits is easy! Just log on to our Member site at davisvision.com and click "Find a Provider," or call us at 1.800.999.5431.

Make an appointment. Tell your provider you are a Davis Vision member with coverage through The Service Employees Benefit Fund. Provide your member ID number, name and date of birth, and do the same for your covered dependents seeking vision services. Your provider will take care of the rest!

100% OF YOUR CALLS & CLAIMS ARE PROUDLY ADMINISTERED IN THE USA

Benefit	Frequency Once every-	In-network Copay	In-network Coverage
Eye Examination	24 months	\$10	Covered in full. <i>Includes dilation when professionally indicated.</i>
Spectacle Lenses	24 months	\$25	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings.)
Frame	24 months		Covered in Full Frames: After copay, any Fashion or Designer level frame from Davis Vision's Collection ¹¹ (retail value, up to \$160). OR, Frame Allowance: \$75 toward any frame from provider plus 20% off any balance ¹⁴ .
Contact Lens Evaluation, Fitting & Follow Up Care	24 months	\$0	Davis Vision Collection Contacts: Covered in full.
Contact Lenses (in lieu of eyeglasses)	24 months	\$25	Covered in Full Contacts: From Davis Vision's Collection ¹ , after copay, up to: Planned Replacement Disposable Four boxes/multi-packs* OR, Contact Lens Allowance: \$100 allowance toward any contacts from provider's supply plus 15% off balance ¹⁴ . OR, Visually Required Contacts: Covered in full with prior approval. *Number of contact lens boxes may vary based on manufacturer's packaging.

Significant savings on optional frames, lens types and coatings!..... Member Price
 Davis Vision Collection Frames: Fashion | Designer | Premier..... \$0 | \$0 | \$25
 Tinting of Plastic Lenses \$0
 Oversize Lenses..... \$0
 Scratch-Resistant Coating..... \$20
 Premium Scratch-Resistant Coating \$30
 Blended Lenses..... \$20
 Ultraviolet Coating \$12
 Anti-Reflective Coating: Standard | Premium | Ultra | Ultimate..... \$35 | \$48 | \$60 | \$85
 Polycarbonate Lenses \$012-\$30
 High-Index Lenses 1.6711.74.....\$551 \$120
 Progressive Lenses: Standard | Premium | Ultra | Ultimate.....\$50 | \$90 | \$140 | \$175
 Polarized Lenses \$75
 Photochromic Lenses (i.e. Transitions®, etc.)³: Plastic | Glass..... \$65 | \$20
 Digital Single Vision Lenses..... \$30
 Trivex Lenses \$50
 Blue Light Filtering.....\$15
 Additional Savings!
 Retinal Imaging.....\$39

1. The Davis Vision Collection is available at most participating independent provider locations.
2. For dependent children, monocular patients and patients with prescriptions of +/-6.00 diopters or greater.
3. Transition is a registered trademark of Transitions Optical Inc.
4. Some limitations apply to additional discounts, discounts not applicable at all in-network providers.

Please note: Your provider reserves the right to not dispense materials until all applicable member costs, fees and copayments have been collected. Contact lenses: Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees above the evaluation and fitting allowance are the responsibility of the member. If contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable. May not be combined with other discounts or offers. Please be advised these lens options and copayments apply to in-network benefits.

(SEBF) Vision Rates

Full-Time

PLAN	BI-WEEKLY PRE-TAX COST SHARE		ANNUAL COST
SEIU Vision			
Tier	Your Cost	UVMHN	
Employee Only	\$0.00	\$2.64	\$0.00
Family	\$1.18	\$4.73	\$31

Part-Time

PLAN	BI-WEEKLY PRE-TAX COST SHARE		ANNUAL COST
SEIU Vision			
Tier	Your Cost	UVMHN	
Employee Only	\$0.53	\$2.11	\$14
Family	\$3.81	\$2.11	\$99

Life Insurance

Term Life Insurance

UVMHN 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:** Full-Time benefits eligible employees are eligible the first of the month following their date of hire or benefits eligibility date. Health information **is not** required.

****INCREASE YOUR ADDITIONAL LIFE INSURANCE - ONE TIME OPPORTUNITY! 2025 Open Enrollment Only**

UVMHN is excited to offer all benefit eligible employees the opportunity to purchase additional life insurance for yourself and/or your spouse up to the guaranteed issue amount without evidence of insurability.

This is a one-time opportunity during the 2025 Open Enrollment period only, from November 4 – November 15, 2024.

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

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

Utilize The Hartford Life Insurance Calculator tool to determine the right amount of coverage to protect your family. Life Insurance Calculator - [The Hartford](#)

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 enrolling for the first time 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.

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

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)



Life Insurance

ADDITIONAL LIFE INSURANCE/AD&D

You can purchase Additional Life Insurance which you pay for after-tax.

PURCHASE:

- Additional Employee Life
- Spouse Life
- Child Life

EVIDENCE OF INSURABILITY

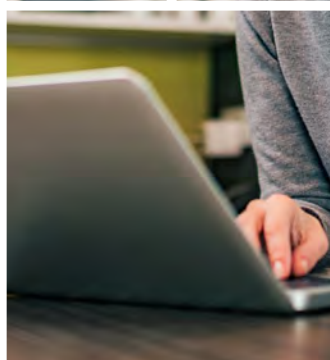
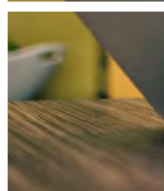
Additional life insurance coverage may require Evidence of Insurability (EOI). EOI is documented proof of good health, which is completed in the application process for life insurance coverage.

- **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.**
- **If an employee does not enroll in a guaranteed issue amount for themselves or their spouse when they first become eligible (i.e., new hire) and enroll later they will be subject to EOI.**

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.

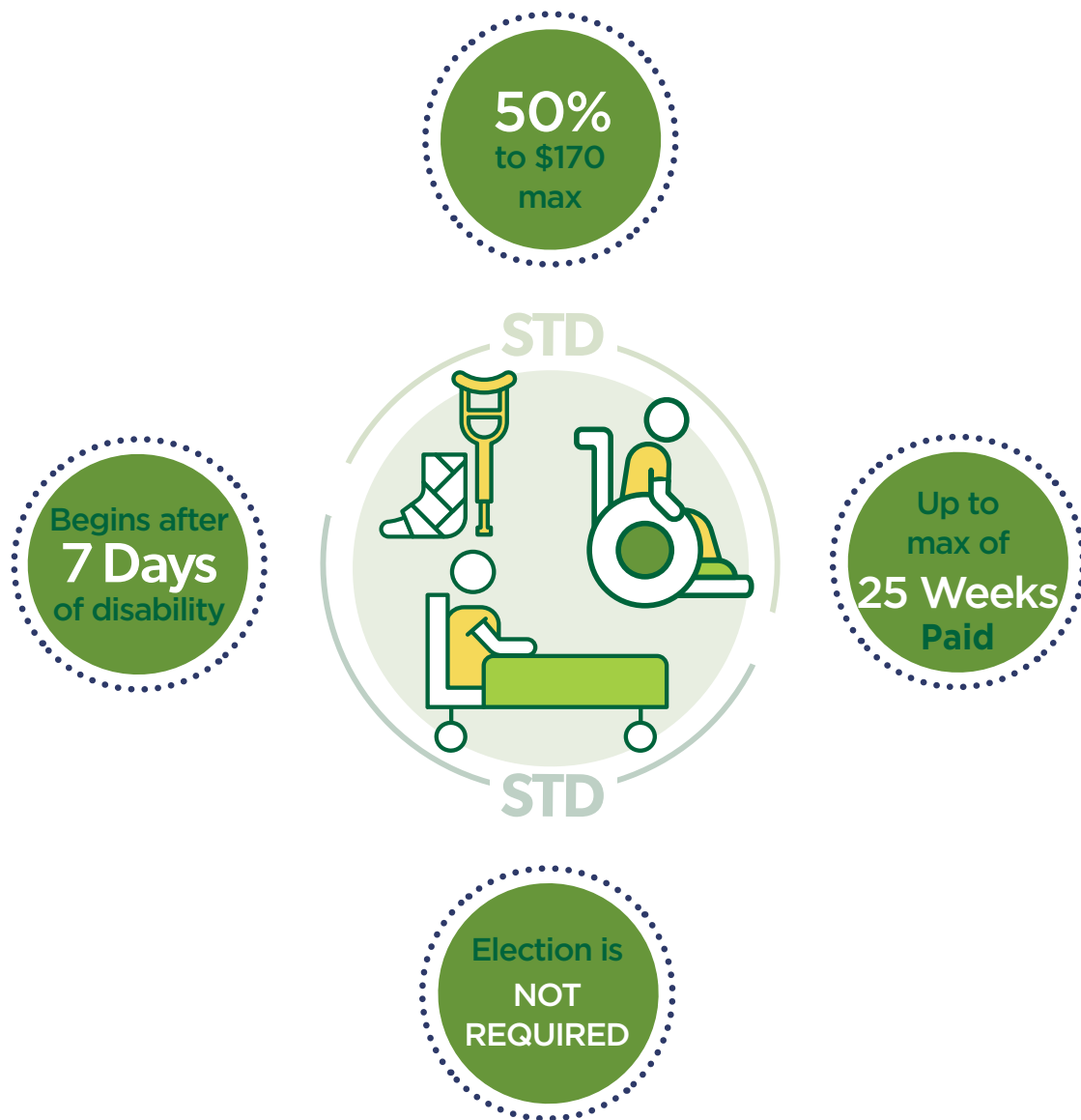
If you terminate employment or become ineligible for coverage, you will be notified by The Hartford via USPS mail on your options and the process to Port or Convert coverage.



NYS Disability

Short-Term Disability

UVMHN partners with The Hartford to administer the New York State short-term disability benefit. This benefit supplements a portion of your income while out of work due to a non-work illness/injury. You are automatically enrolled once you become eligible.



STD: After a seven calendar day waiting period, current benefits are capped at \$170 per week or 50% of weekly base compensation, whichever is less pay for up to a maximum of 25 weeks.

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

New York State (NYS) STD is available through The Hartford to full-time and part-time employees after completion of four (4) consecutive weeks for a covered NYS employer.

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

UVMHN 400 Plan Only

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](https://www.uvmh.org/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](https://www.thehartford.com/mybenefits)

USE WEBSITE TO:

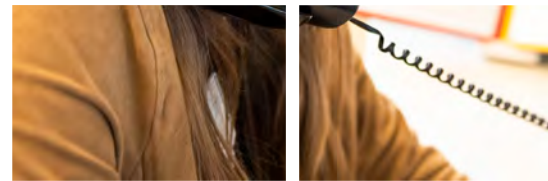
- Start a Claim
- Check Claim Status

DISABILITY PLANS:

- NYS Short-Term Disability

ADDITIONAL ASSISTANCE:

- Occupational Health & Wellness
518-481-2415
- Stephanie Barse
518-481-8092
- **Email:**
sdeuyor@allcehyde.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).

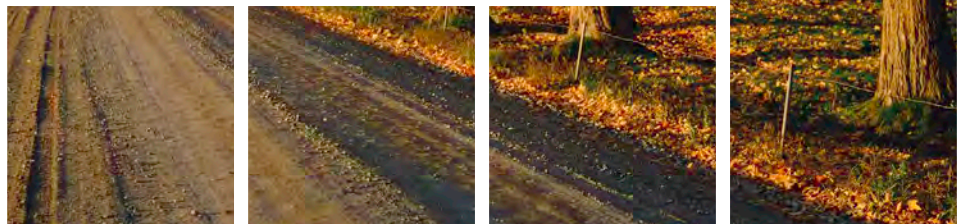
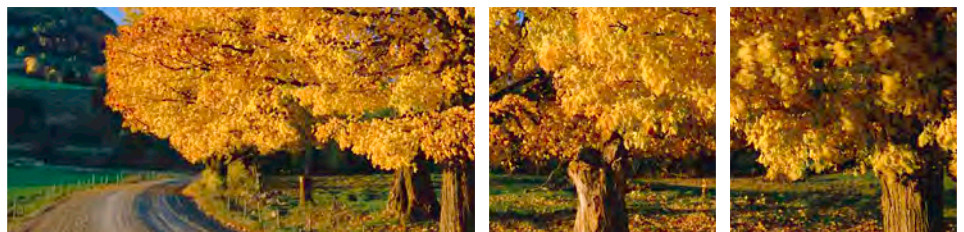
Occupational Health & Wellness is committed to helping improve the health and wellness of our employees. We support health improvement programs which address mental, physical, spiritual and social issues. To schedule an appointment call (518) 481-2415.

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 AHMC.

- Employee Counseling
- Fall Hike
- Farmers Market
- Massage
- Onsite Fitness Center
- Ski Passes
- Strozzi Resiliency
- Vendor Fair
- Wellness for the Soul
- Wellness Fun Book Club



Employee Wellness Gym

As an added benefit, the gym below the offices of Alice Hyde's Occupational Health & Wellness Department is open. Our employees may access the gym 24/7 — at no cost! To gain access, visit the AHMC Human Resources Department and sign a liability waiver. The gym includes:

- Treadmills
- Elliptical machines
- Exercise bikes
- Yoga mats
- Dumbbells
- And more

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



Friends & Family Plan

UVMHN is excited to provide additional support for your loved ones! 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 AHMC email, you will receive two emails from Headspace
4. **Existing Members:** verify your account with your AHMC email, you will receive one email from Headspace

Download the app and get some Headspace!

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



Click the links below to:

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

Your Mental Health Matters

No matter what you are going through, Lyra can help. Get matched to confidential mental health support today.

Your feelings affect your well-being every day. Whether you're trying to navigate multiple feelings, experiencing grief, burnout at work and/or at home, feeling stressed, anxious, depressed, having relationship concerns or seeing a loved one suffer Lyra can help you feel more balanced. Lyra offers confidential care to support your emotional and mental health well-being, how, when and where you need it. You can choose from a diverse network of providers including mental health coaches and therapists. If you're not looking for a coach or therapist, you can find support through an online library of self-care tools and much more.

Who is eligible for Lyra Health?

Eligible Employees: All UVM Health Network (UVMHN) Part-Time, Full-Time, Per Diem and Direct Hire Temporary.

Eligible Dependents & Family Members: Eligible employees' household family members, including minor children. Dependent children up to the age of 26 are not required to live in the eligible employees' household.

Canadian Residents: While outside of the U.S. certain program benefits may not be available and children must be age 12+. While inside the U.S. all program benefits will be available, except certain specialized programs. For specialized programs, the Lyra in- country care navigation will provide resources within Canada.

Lyra Program Benefits

Therapy Sessions: 10 FREE sessions per person, per year (in- person or virtual).

Mental Health Coaching: Coaches can help with life's challenges such as anxiety, stress, parenting, and more thru video or live messaging (age 18+).

Library of Resources: Build healthy habits with an on-demand self- care library with videos, articles and meditations (age 18+).

Get started with Lyra in three easy steps:

1. Create a free account at uvmhn.lyrahealth.com or contact the Care Navigator Team 24 hours a day, 7 days a week by calling your in-country phone number below.
US: (888) 632-3189 | CAN: 1 800 874 3817
2. Take the care assessment to get matched with high-quality providers who have appointments available right away.
3. Meet with your provider to start feeling better.

Lyra Renew: This program can help change someone's relationship with alcohol, whether they want to drink less or stop drinking entirely (age 18+).

Dialectical Behavioral Therapy (DBT): Treatment for suicidal ideas/ thoughts and non-suicidal self-harm.

Work-Life Services: Financial, Legal, Identify Theft, Child, Elder, Pet Care.

Eligible employees/dependents enrolled in a UVMHN Blue Cross Blue Shield medical plan, have access to:

Medication Management: Medication consultation, symptom/side effect tracking and follow-up sessions with a physician.

Continued Care after 10 FREE Sessions: Sessions will be billed to your UVMHN medical plan.

Cost-Share: For these services, you will be responsible for the applicable Tier 1 (Domestic) network outpatient mental health cost- share (i.e., deductible, copay, coinsurance).

For cost-share information, go to the intranet for your location to access the UVMHN Benefits website. On the UVMHN benefits website go to: Tools & Resources> Plan Documents & Required Notices>Summary of Benefits & Coverage (SBC).

Learn more at uvmhn.lyrahealth.com

Lyra Health, Inc. works in partnership with Lyra Clinical Associates P.C. and other contracted partners to be your Lyra Care Navigator Team and deliver clinical services. For more information, please contact Lyra's Care Navigator Team.

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

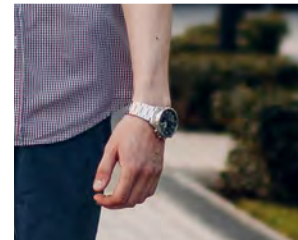
Accident insurance pays a lump sum if you become injured because of an accident. It allows you to claim benefits even if the injuries do not keep you out of work. Accident insurance may also complement health insurance if an accident causes you to have medical expenses that your health insurance doesn't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

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

Wellness Benefit - Critical Illness

Get paid for preventive exams!

Employee: \$50

Covered Spouse: \$50

Covered Child(ren): \$25 each (up to \$100)

Covered health screening tests include annual physicals, dental and vision exams.

Hospital Indemnity Insurance

Hospital Indemnity insurance is a plan designed to pay costs associated with a hospital admission that may not be covered by other insurance. The plan covers employees who are admitted to a hospital or ICU for a covered sickness or injury.

Even if your Medical insurance covers most of your hospitalization, you can still receive payments from your Hospital Indemnity insurance plan to cover extra expenses while you recover.

HOW DOES HOSPITAL INDEMNITY INSURANCE WORK?

You pay monthly premiums for your Hospital Indemnity insurance plan. If you are admitted to the hospital for an injury or illness, your Hospital Indemnity plan makes cash payments to you.

And with the payments going directly to you, you can use these emergency funds to pay for costs not covered by your Medical insurance, including medical insurance deductibles, copays and coinsurance, child care expenses while you are in the hospital or cost-of-living expenses as you recover.



Voluntary Benefits

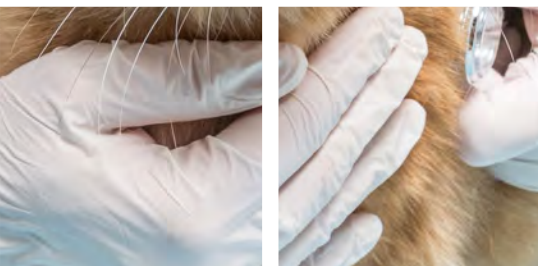
ID Protection & Pet Insurance

Allstate Identity Protection

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

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

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



Pet Insurance



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

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

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

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®](#)



Vacation Benefits



Paid Time Off (PTO)

FULL-TIME TECHNICAL UNIT

For the following PTO schedules, one day is equivalent to eight hours.

- **Vacation days:** 10 days vacation after completion of 1 year; 15 days after completion of 5 years **consecutive full time equivalent employment**; 18 days after 8 years **consecutive full time equivalent employment**; 19 days after 9 years **consecutive full time equivalent employment**; 20 days after 10 years **consecutive full time equivalent employment**; 22 days after 13 years **consecutive full time equivalent employment**; 23 days after 23 years **consecutive full time equivalent employment** and 24 days after 25 years **consecutive full time equivalent employment**.
- **Sick leave:** If hired before August 10, 2009 accrue 1 sick day per month with a maximum accumulation of 170 days. If hired on or after August 10, 2009 accrue 6 hours per month with a maximum of 100 days.
- **Personal leave:** If hired before July 25, 2018, 5 days per calendar year. If hired on or after July 25, 2018, accrue 2 days once probationary period is complete. Once 4 years full time equivalent employment, accrue 3 days. Once 8 years of full time equivalent employment, accrue 5 days.

- **Holidays:** 7 paid holidays per year. Those holidays are New Year's Day, Memorial Day, Labor Day, July 4th, Thanksgiving, Christmas, and a February floating holiday.

PART-TIME TECHNICAL UNIT

- **Vacation days: Prorated vacation allowance will be based on the actual hours worked in the prior anniversary date of employment year.** Time is prorated on a 40-45-50-55-60-65-70-75-80-85-90% formula.
- **Sick Time:** Shall accrue at the rate of one day per three-month period. Maximum accumulation of eighteen days.
- **Personal Time: If hired before July 25, 2018,** pro-rated on a 40-45-50-55-60-65-70-75-80-90% basis. **Personal time allowance will be based on the actual hours worked in the prior anniversary date of employment year.** If hired on or **after July 25, 2018,** accrue 1 day once probationary period is complete. Once 8 years full time equivalent employment 5 personal days, prorated in accordance with AHMC policy/contract. **Prorated Personal time Allowance will be based on the actual hours worked in the prior anniversary date of employment year.**
- **Holidays:** Holiday time for regular part-time shall be granted and paid for according to a 40-45-50-55-60-65-70-75-80-90% formula. This benefit and formula will apply only to those regular part-timers who have completed one (1) full year of service as of anniversary date of employment. The prorated benefit produced by the formula will depend upon hours worked during the preceding anniversary year. Similar anniversary year computations will be performed each year thereafter.

Vacation Benefits

FULL-TIME SERVICE AND MAINTENANCE

For the following PTO schedules, one day is equivalent to eight hours.

- **Vacation days:** 10 days vacation after completion of 1 year; 15 days after completion of 5 years **consecutive full time equivalent employment**; 18 days after 8 years **consecutive full time equivalent employment**; 19 days after 9 years **consecutive full time equivalent employment**; 20 days after 10 years **consecutive full time equivalent employment**; 22 days after 13 years **consecutive full time equivalent employment**; 23 days after 23 years **consecutive full time equivalent employment** and 24 days after 25 years **consecutive full time equivalent employment**.
- **Sick Time:** If hired before July 1, 2009 accrue 1 sick day per month with a maximum accumulation of 170 days. If hired on or after July 1, 2009 accrue 6 hours per month with a maximum of 100 days.
- **Personal Time:** If hired before July 25, 2018, 5 days per calendar year. If hired on or after July 25, 2018, accrue 2 days once probationary period is complete. Once 4 years full time equivalent employment, accrue 3 days. Once 8 years of full time equivalent employment, accrue 5 days.
- **Holidays:** New Year's Day, February floating holiday, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas.

PART-TIME SERVICE AND MAINTENANCE

- **Vacation days:** Prorated vacation allowance will be based on the actual hours worked in the prior anniversary date of employment year. Time is prorated on a 40-45-50-55-60-65-70-75-80 % formula.
- **Sick time:** Shall accrue at the rate of one day per three-month period. Maximum accumulation of eighteen days.

- **Personal time:** If hired before July 25, 2018, pro-rated on a 40-45-50-55-60-65-70-75-80% basis. **Personal time allowance will be based on the actual hours worked in the prior anniversary date of employment year.** If hired on or after July 25, 2018, accrue 1 day once probationary period is complete. Once 8 years full time equivalent employment 5 personal days, prorated in accordance with AHMC policy/contract. **Prorated Personal time Allowance will be based on the actual hours worked in the prior anniversary date of employment year.**
- **Holidays:** Holiday time for regular part-time shall be granted and paid for according to a 40-45-50-55-60-65-70-75-80% formula. This benefit and formula will apply only to those regular part-timers who have completed one (1) full year of service as of anniversary date of employment. The prorated benefit produced by the formula will depend upon hours worked during the preceding anniversary year. Similar anniversary year computations will be performed each year thereafter.

Vacation Buy-Out

Employees may request wages in lieu of taking vacation days off ("vacation buy-outs"), which will be granted once per employee per calendar year, with the request not to exceed 40 hours. In addition, an employee must have a minimum balance of 40 vacation hours, separate from the requested vacation buy-out. The dollars are added to your paycheck as additional income and the taxes are withheld at the supplemental rate. Approval of vacation buy-outs may be suspended or permanently discontinued based on budgetary considerations.

Tuition Reimbursement

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

Tuition Assistance ALWAYS IMPROVING

Upon your 1-year of continuous employment, regular part-time or full-time employees are eligible for tuition reimbursement. 1-year of continuous employment must be completed prior to the beginning of a course for which he/she is requesting tuition reimbursement.

Full-time employees will be reimbursed at the rate of 100% of credit hours satisfactorily completed, up to

\$2,500 per calendar year. The maximum annual amount for reimbursement will be prorated for a part-time employee based on hours worked in the previous year.

In order to receive Tuition Reimbursement, employees must fill out a Tuition Reimbursement Request Form and submit 30 days prior to the course start date. Request approval is required prior to start of a course in order to receive reimbursement.

Employee Discounts

Alice Hyde Medical Center employees are eligible for discounts from a wide range of businesses. Employee Discounts can be found on the intranet.

Discounts Include

- **Automotive**
- **Banking**
- **Electronics**
- **Entertainment**
- **Food & Lodging**
- **Physical Activity and Wellness**
- **Retail Services**
- **Seasonal Discounts**
- **Health & Wellness**
- **Fitness**
- **Gift Certificates**
- **And More!**



DISCOUNTS SUBJECT TO CHANGE

The link to products and vendors is being provided as a convenience and for informational purposes only.

AHMC does not endorse any of the products or vendors linked to this Website.

AHMC makes no effort to independently verify the quality or reliability of any of the products or vendors linked to this Website.

AHMC specifically disclaims any and all liability for any claims or damages that may result from providing a link to these products and vendors.

REGISTER NOW

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Use: Member ID 20058505



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 AHMC 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.

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](#).

Paid Family Leave (PFL)

NYS PFL is job protected, paid time away from work for employees that meet the qualifying reasons. PFL is utilized:

- To care for a family member with a serious health condition (family member defined as spouse, parent-in-law, domestic partner, grandparent, child, grandchild or parent)
- To bond with a child
- For military exigencies (defined under FMLA) PFL requires an employee to provide 30 days advanced foreseeable notice for a leave event. If not foreseen, notice must be given as soon as practicable. PFL covers employees working 20 hours or more per week after being employed for 26 consecutive weeks. Employees working under 20 hours are not eligible until they have worked 175 consecutive days.

Employees are entitled to 12 weeks of leave time in a 52-week interval. Benefits payable will be 67% of weekly wage, but no more than \$1,151.16 per week. (Taxable benefits.)

NYS PFL is completely employee funded. These will be weekly deductions in the amount of 0.373% of weekly pay, capped at an annual maximum of \$333.35, via payroll deduction.

Please notify your manager and OHW of your upcoming absence from work.



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

3 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

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

UVMHN/AHMC 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

Alice Hyde Medical Center is fully-insured for Workers' Compensation, which means UVMHN - AHMC is responsible to compensate you for lost wages and medical benefits if it is determined that your illness or injury is related to or caused by your work according to NYS Workers' Compensation Law.

IMMEDIATELY FOLLOWING AN ACCIDENT OR INJURY YOU SHOULD:

- In the event of a serious injury, call 911 or proceed to the nearest emergency room
- Report the incident to your manager and complete the online Report of Event (ROE) form with your manager by the end of your shift
- Advise Occupational Health & Wellness of your work status following your medical evaluation
- Reporting a Work Related Illness or Injury Policy
- Intranet



Leave of Absence for Military Service

UVMHN/AHMC 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. AHMC 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 AHMC 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 AHMC 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 AHMC'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.

Other Leaves of Absence

BEREAVEMENT LEAVE

Offered to provide continued pay during time off from work as a result of a death in the family. Employees may be granted up to three paid scheduled workdays following a death in the immediate family: spouse; parent; step-parent; child; step-child; sibling; step-sibling; grandparent; grandchild; mother-in-law; father-in-law; son-in-law; daughter-in-law; sister-in-law; or brother-in-law. Requests for exceptions for other close family or household members may be granted at the discretion of the manager.

JURY DUTY

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

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



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

UVM HEALTH NETWORK'S ACTION UNDER ACA

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.

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 or such other deadline as permitted by the IRS.

THERE ARE THREE TESTS FOR DETERMINING ELIGIBILITY UNDER THE ACA:

• 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.

• 2 - Hire With Look Back:

Employee is hired into a position that is not 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 during the first 12 months of employment, the employee averages at least 30 hours per week, the employee is eligible for coverage one month after completing 12 months of employment.

• 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.

2023		2024					2025					
Nov	Jan	Mar	May	Jul	Sep	Nov	Jan	Mar	May	Jul	Sep	Nov
Measurement Period <ul style="list-style-type: none"> • Total number of hours worked: 1,596 • Average number of hours worked per month: 133 						Wait Period	Stability Period <ul style="list-style-type: none"> • Employee is determined to be full time • Employee must be offered benefits 					

With some exceptions, changes in hours worked during a stability period, do not change an employee's eligibility for medical coverage.

ACA-ELIGIBLE EMPLOYEE MEDICAL COVERAGE AT UVMHN

ACA - eligible employees are offered the UVMHN HDHP 3300. 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).

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.

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 during Open Enrollment.

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

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 (with extensions where permitted by the IRS), whether they elect UVMHN coverage or not. This form details the coverage made available by UVMHN in the prior year.

IRS FORM 1095-C

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	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 (with extensions where permitted by the IRS). 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 (with extensions where permitted by the IRS) 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.

<p>COBRA Administrator: EBPA</p> <p>CONTACT INFORMATION: Phone (888) 232-3203</p>	<p>PLANS AVAILABLE FOR CONTINUATION:</p> <ul style="list-style-type: none">• Medical• Dental• Vision• Health Care Flexible Spending Account• Lyra <p>PREMIUMS: The full cost plus a 2% administration fee is paid for by you. Premiums are paid directly to the EBPA</p>
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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 qualifying event
Reduction in Hours of Employment - making you ineligible for benefits		
Dependent Child who attains age 26	Impacted Dependent	36 months after qualifying event
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 qualifying event
You become enrolled in Medicare coverage less than 18 months before your initial qualifying event (termination of employment or reduction in hours)	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 both 60 days after you are determined by the Social Security Administration to be disabled and within the original 18-month period.

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



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		0.0684	

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 \times \$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
 $\$250,000 / \$1,000 = \$250 \times \$0.052 = \$13.00$ (monthly)
 Annual Premium will be \$156.00 or \$6.00 bi-weekly

IMPUTED INCOME RATES ON EMPLOYER PAID LIFE INSURANCE

CALCULATING IMPUTED INCOME ON EMPLOYER PAID LIFE INSURANCE ABOVE \$50,000	BI-WEEKLY IMPUTED INCOME RATE PER \$1,000 OF BENEFIT	
	<p>To determine the amount of imputed income - use your age at the end of the calendar year and the rates noted to the right.</p> <p>You have \$64,000 in term coverage</p> <p>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)</p> <p>$\\$14,000 / \\$1,000 = \\$14 \times \\$0.069 = \\0.97</p> <p>You would have \$0.97 of additional taxable income each pay period or \$25.22 annually.</p>	Age 24 and Under
Age 25 - 29		\$0.028
Age 30 - 34		\$0.037
Age 35 - 39		\$0.042
Age 40 - 44		\$0.046
Age 45 - 49		\$0.069
Age 50 - 54		\$0.106
Age 55 - 59		\$0.198
Age 60 - 64		\$0.305
Age 65 - 69		\$0.586
	Age 70 and Over	\$0.951



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

Note: Descriptions of common health insurance terms reference UVMHN plan specific examples and may apply differently under the Excellus plan.

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 1650 and HDHP 3300).

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. A more detailed definition is in the Summary Plan Description.

MEDICARE

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

- **MEDICARE PART A (HOSPITAL INSURANCE)**
Covers inpatient services, including hospital stays, home health, hospice, and limited skilled nursing facility services.

- **MEDICARE PART B (MEDICAL INSURANCE)** Covers outpatient services, including physician services, medical supplies, and other outpatient treatment. After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).
- **MEDICARE PART C (MEDICARE ADVANTAGE PLANS)** A managed Medicare Advantage plan. With this type of plan, qualified individuals and groups would have their Medicare coverage provided through an insurer, such as CDPHP. They must be eligible for Medicare Part A and Part B. Medicare Advantage plans can provide prescription drug coverage (Part D).
- **MEDICARE PART D (PRESCRIPTION DRUG COVERAGE)** A federal program to help cover the costs of prescription drugs for Medicare recipients in the United States.

NETWORK

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

OUT-OF-POCKET MAX

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



OUTPATIENT CARE/AMBULATORY CARE

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

PREMIUM

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

PRIOR AUTHORIZATION

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

ROUTINE/PREVENTIVE VISIT

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

SPECIALIST

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

LEGAL NOTICES



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 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 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>

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 manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. The deductibles and coinsurance are found in the Plan's summary plan description. Contact 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 have any questions about the coverage of mastectomies and reconstructive surgery under the Plan, please call Member Services at (833) 578-1126, Monday Friday, 8:30 a.m. to 8:00 p.m., or visit myhealthtoolkitvt.com.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT OF 1996

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

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out of pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

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

You are protected from balance billing for:

Emergency services

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

Certain services at an in network hospital or ambulatory surgical center

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

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

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

When balance billing isn't allowed, you also have the following protections:

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

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

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

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 threat, including the target of the threat.
- If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- If you do not object, you are not present, or your consent cannot be obtained because of your incapacity or an emergency circumstance, the Plan may, in the exercise of its professional judgment, disclose to your family member, relative, or other person who is responsible for your care, or for the payment of your care, your PHI directly relevant to such care or payment, if the Plan concludes that disclosure is in your best interests, including following your death.
- For fundraising purposes, if the information used or disclosed is demographic information, including name, address, or other contact information, age, gender, and date of birth, dates of health service information, department of service information, treating physician, outcome information, and/or health insurance status. Each fundraising communication made to you will provide you with an opportunity to opt-out of receiving any further fundraising communications. The Plan will also provide you with an opportunity to opt back in to receive such communications if you should choose to do so.
- For those specialized government functions set forth in the regulations promulgated pursuant to HIPAA or such other purposes provided under HIPAA.

We are required to disclose your PHI to the Secretary when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

YOUR RIGHTS AS INDIVIDUALS

Right to Request Restrictions on Uses and Disclosures of PHI

If you wish, you may (1) request that the Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or (2) request that the Plan restrict uses and disclosures of your PHI to family members, relatives, friends or other persons

identified by you who are involved in your care or the payment for your care. Please note, however, that the Plan is not required to agree to your request. You have the right to request that your provider not disclose health information to the Plan if you have paid for a service in-full, and the disclosure is not otherwise required by law. The request for restriction to the Plan will only be applicable to that particular service. You will have to request a restriction for each service thereafter from your provider.

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

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

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

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, 2024.

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 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 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 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.
- (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 under age 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 1650 & 3300 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 1650 or 3300 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: 10/1/2024

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-1510H5
1 South Prospect St.
Burlington, VT 05401

The UVMHN Chief Compliance Officer, 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, the UVMHN Chief Compliance Officer is available to help you. If you have a complaint or concern, you may contact them directly at (802) 847-8556.

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

1-518-2000 x 5066 . מאַזקעמפּיִיאָ: ביזאָ ריזא טדער שידיא, זענען זאָהראַפּ ראַפּ דייאָ קאַרפּש פּליה סעסיווירעס יירפּ זאָפּ לאַצפּאָ. טפּור -1

Bengali

লক্ষ্য করনঃ যিদ আপিন বাংলা, কথা বলেত পােরন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপলব্ধি আছ।
ে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 5066 ملحوظة: 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

نیرک .1-518-2000x5066نیرک رادریخ: رگا پآ ودرآ ےتلوب نیہ، وت پآ وک نابز یک ددم یک تامدخ تغم 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.

Albanian

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 July 31, 2024. Contact your State for more information on eligibility –

<p>ALABAMA – Medicaid</p> <p>Website: http://myalhipp.com/ Phone: 1-855-692-5447</p>	<p>ALASKA – Medicaid</p> <p>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</p>
<p>ARKANSAS – Medicaid</p> <p>Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p>CALIFORNIA – Medicaid</p> <p>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</p>
<p>COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)</p> <p>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</p>	<p>FLORIDA – Medicaid</p> <p>Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268</p>

GEORGIA - Medicaid	INDIANA - Medicaid
<p>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</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA - Medicaid and CHIP (Hawki)	KANSAS - Medicaid
<p>Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY - Medicaid	LOUISIANA - Medicaid
<p>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: KIHIPPPROGRAM@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</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE - Medicaid	MASSACHUSETTS - Medicaid and CHIP
<p>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</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA - Medicaid	MISSOURI - Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA - Medicaid	NEBRASKA - Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcftp.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 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.nifamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	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 Rlte 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	Utah’s Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
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?

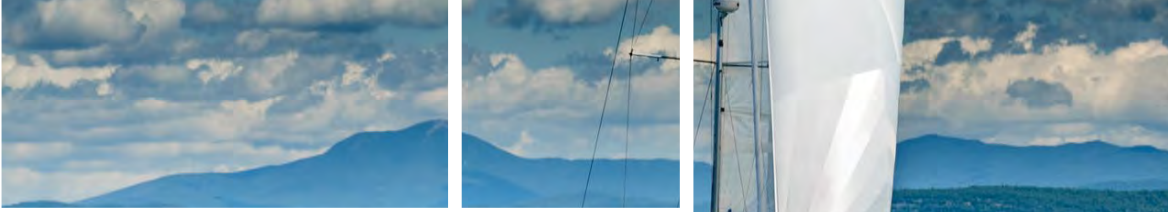
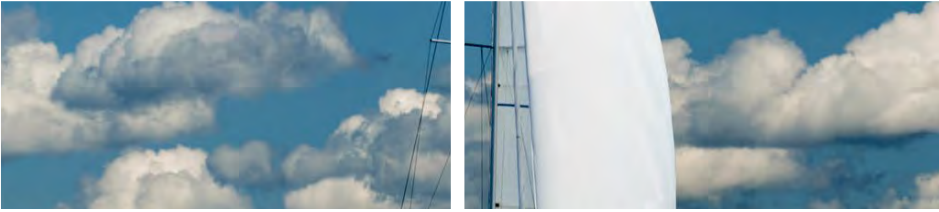
For more information about your coverage offered by your employer, please check your summary plan description or contact [HR Solution Center](mailto:HRSolutionCenter@uvmhealth.org) 111 Colchester Avenue, Burlington, VT 05401; HRSolutionCenter@uvmhealth.org; 844-777-0886

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.

THE
University of Vermont
HEALTH NETWORK

Alice Hyde Medical Center



2025

