

2021 Benefits Policy Guidebook

Porter Medical Center



THE
University of Vermont
HEALTH NETWORK

Porter Medical Center

PorterMedical.org

The heart and science of medicine.

Table of Contents

INTRODUCTION

Introduction	3
------------------------------------	---

BENEFIT BASICS

Eligibility	4
Enrollment	4, 5, 8
Effective Dates	4, 5, 7
Eligible Dependents	6
Paying for Coverage	6
Qualifying Life Events	7

HEALTH & WELLNESS

Medical Insurance	9-11
Prescription Coverage	10, 12, 13
Flexible Spending Account (FSA)	
- Health FSA	14, 15, 18, 19
- Limited Purpose FSA	14, 15, 18, 19
- Dependent Care FSA	16, 18, 19
Health Savings Account (HSA)	17-19
Dental	20, 21
Vision	22, 23
Wellness	24

FINANCIAL PROTECTION

Life Insurance	25, 26
Short-term Disability	27, 28
Long-term Disability	28

RETIREMENT

403(b)	29-31
------------------------------	-------

VOLUNTARY BENEFITS

Hospital Indemnity	32, 33
Pet Insurance	34
Identity Theft Protection	35

TIME AWAY

Combined Time Off (CTO)	36
Extended Illness Reserve	37
CTO Sell	38
CTO Cash-in	38
Leave of Absences	39-42

WORK-LIFE

Employee & Family Assistance Program	43
Tuition Advance Program	44
Employee Discounts	44

LEGAL NOTICES

ACA Overview	45, 46
COBRA	47, 48
Annual Notices	49, 50

APPENDIX

Rates	51-54
Vendor Contact Information	55
Common Health Insurance Terminology	56, 57

Introduction

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

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

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

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

COMMIT TO YOURSELF

Choice gives you flexibility - and with flexibility comes responsibility.

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

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

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



VALUE AND COST

Get the biggest bang for your buck!



ACCESS

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



CHOICE

Choose the best option for your needs and preferences.



PROTECTION

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



COMMUNICATE

Convey information to allow for informed decision making.



SUPPORT

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

Eligibility

To participate in Porter Medical Center benefits, you must be a full-time or part-time employee with scheduled bi-weekly hours between 40-80 hours. We have two types of benefit eligible employment classifications:

- **Full-time Regular**
Hired to regularly work 60-80 hours in a two-week pay period. Full-time employees are eligible for medical, dental, vision, saving and spending accounts, life insurance, and disability insurance.
- **Part-time Regular**
Hired to regularly work between 40 and 59 hours in a two-week pay period. Part-time employees are eligible for life and disability insurance.

Porter Medical Center has one employee classification that is not eligible for benefits (unless noted):

- **Part-time, Per Diem**
Hired to work on an “as needed” basis.

ENROLLMENT

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

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

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



WHEN IS COVERAGE EFFECTIVE

ANNUAL OPEN ENROLLMENT

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

HIRE OR BENEFIT ELIGIBILITY DATE

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

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

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

EXAMPLE:

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

WHEN BENEFITS BEGIN AND END

BENEFIT TYPE	Who Pays		How To Enroll In Coverage	Benefit Start Date	Making Changes	
	Porter	You			Qualifying Event	Open Enrollment
403(B)	✓	✓	Fidelity at Work	Your contributions - immediately	Anytime	
MEDICAL INCLUDING PRESCRIPTION COVERAGE	✓	✓	Workday	1st of month following date of hire or qualifying event date. If your date of hire or qualifying event date is the 1st of the month, your benefits will begin that day. Any benefit changes resulting from the birth of a child will begin on the date of the child's birth.	✓	✓
HOSPITAL INDEMNITY		✓			✓	✓
DENTAL	✓	✓			✓	✓
VISION		✓			✓	✓
FLEXIBLE SPENDING ACCOUNT		✓			✓	✓
HEALTH SAVINGS ACCOUNT	✓	✓			Anytime	
LIFE INSURANCE (1 TIMES ANNUAL SALARY)	✓		Automatically Enrolled		✓	✓
VOLUNTARY ADDITIONAL LIFE, SPOUSE LIFE, AND CHILD LIFE		✓	Workday Evidence of Insurability will be emailed after enrollment, if required.	1st of month following 90 days of employment. Note: Pre-existing condition clause applies on plan.	✓	✓
SHORT-TERM DISABILITY		✓			✓	✓
LONG-TERM DISABILITY	✓		Automatically Enrolled		N/A	
COMBINED TIME OFF (CTO)	✓		Automatically Enrolled	Hire Date or Benefit Eligibility Date	N/A	
CTO SELL	✓		Paper Form during Open Enrollment and returned to HR	January 1		✓
CTO CASH-IN	✓					✓
TUITION ADVANCE PROGRAM	✓		Human Resources	Start of course following 6 months of service. Refer to Policy. More Info	N/A	
IDENTITY THEFT PROTECTION		✓	Allstate Identity	January 1 following enrollment		✓
PET INSURANCE		✓	Nationwide	14 days following enrollment	Anytime	

ELIGIBLE DEPENDENTS

YOU CAN ELECT TO COVER THE FOLLOWING DEPENDENTS IN PORTER BENEFITS:

- Spouse or Civil Union Partner
- Legally Dependent Child up to age 26
- Disabled Dependents of any age

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

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

FOR ANNUAL OPEN ENROLLMENT:

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

HIRE OR BENEFIT ELIGIBILITY DATE:

Documentation must be provided within 31 days.

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

FOR EXAMPLE:

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

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

PAYING FOR COVERAGE

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

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

QUALIFYING LIFE EVENTS ALLOWING BENEFIT CHANGES

IRS QUALIFYING LIFE EVENT	Life Event Examples	Who can enroll/unenroll	Deadline to Request Change in Coverage	Coverage Start or End Date of Coverage	Timeline Examples
Annual Open Enrollment	1 time per year opportunity to elect, drop, or change benefits	Employee Spouse Dependent(s) of Employee	Enrollment is in November. Elections must be made prior to start of the new year.	January 1	Open Enrollment: 11/15 - 11/30 Effective Date of Coverage: 01/01
A Loss of eligibility for other coverage	<ul style="list-style-type: none"> • Employment Change (you or your spouse) • Divorce or Legal Separation • Child becomes an ineligible dependent due to age (includes turning 26 and losing coverage through a parent) • Death of Spouse 	Employee Spouse Dependent(s) of Employee	31 days after loss of coverage	First of month following loss of coverage	Loss of coverage: 02/15 Enrollment window: 02/15 - 03/15 Effective date of coverage: 03/01
Gain of coverage under another qualified health plan	Gain of coverage through spouse/civil union partner (includes election of coverage as a new hire or annual enrollment)	Employee Spouse Dependent(s) of Employee	31 days after gain in coverage elsewhere	End of month in which coverage is obtained	Date of gaining coverage: 03/01 Enrollment window: 03/01 - 04/01 Effective date of coverage ending: 02/28
Marriage	Getting Married (includes gain of dependents through Marriage)	Employee Spouse Dependent(s) of Employee	31 days after marriage	First of month following marriage	Date of Marriage: 03/10 Enrollment window: 03/10 - 04/10 Effective date of coverage: 04/01
Change in Family Status	<ul style="list-style-type: none"> • Birth of Child • Adoption or Placement for Adoption • Legal Guardianship Appointment 	Employee Spouse Dependent(s) of Employee	60 days after change in Family Status	Date of change in Family Status Action required to add child beyond 60 days to benefits.	Date of Birth: 05/05 Enrollment window: 05/05 - 07/05 Effective date of coverage: 05/05 Charges for coverage would not begin until 07/05
Loss of Premium Assistance Subsidy	Termination of eligible for Medicaid or a state Children's Health Insurance Program (CHIP)	Employee, who is eligible but not enrolled Dependent(s) of Employee	60 days after loss of coverage	First of month following loss of eligibility	Loss of eligibility: 07/15 Enrollment window: 07/15 - 09/15 Effective date of coverage: 08/01
Gaining Premium Assistance Subsidy	Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP	Employee, who is eligible but not enrolled Dependent(s) of Employee	60 days after eligibility for a premium assistance subsidy is determined	First of month following gain in premium assistance	Gain of Subsidy: 09/22 Enrollment window: 09/22 - 11/22 Effective date of coverage ending: 09/30

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

How to Enroll in your Benefits

1 REVIEW YOUR BENEFIT OPTIONS.

Review this guide and utilize our online resources to determine your benefits eligibility. Decide which options work best for you and your family.

2 GATHER YOUR INFORMATION.

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

3 ENROLL THROUGH WORKDAY.

[Workday](#) is UVM Health Network's web-based human resources, payroll, and benefits system.

For help logging into Workday, please contact the IS Helpdesk at (802) 847-1414.

For help using the Workday system, review the link for step-by-step guides or contact the HR Service Center at (802) 847-2825, option 2.

4 PRINT.

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

5 FOLLOW UP WITH REQUIRED DOCUMENTATION.

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

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

6 REVIEW YOUR PAYCHECK.

It is always important, to review your paycheck and ensure your benefit deductions and pay are accurate.

NEED HELP UNDERSTANDING YOUR BENEFITS?

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

- Hours:
Monday - Friday, 8am - 4:30pm
- Email:
Benefits@UVMHealth.org
- Phone:
(802) 847-2825, option 2
- [Intranet](#)



QUESTIONS REGARDING YOUR PAYCHECK, KRONOS, OR TAX WITHHOLDING?

PAYROLL IS AVAILABLE TO HELP ANSWER YOUR QUESTIONS.

- Hours:
Monday - Friday, 8am - 4:30pm
- Phone:
(802) 388-4780, option 6

Medical Insurance

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

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

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

NATIONAL BCBS NETWORK

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

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

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

PREVENTIVE OR DIAGNOSTIC?

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

BENEFIT PROVIDED BY:
Blue Cross Blue Shield
of Vermont

CONTACT INFORMATION:
(800) 422-6668

GROUP NUMBER:
25377

WEBSITE:
bcbsvt.com

WEBSITE FEATURES:

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

PLANS OFFERED:

- [UVMHN - 250 Plan](#)
- [UVMHN - 400 Plan](#)
- [UVMHN HDHP with HSA Plan - 1500](#)
- [UVMHN HDHP with HSA Plan - 3000](#)

COVERAGE LEVELS:

- 1 Person
- 2 Person
- Family

PREMIUMS:

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

OTHER HELPFUL DOCUMENTS:

- [Plan Overview](#)
- [2021 Rates](#)
- [Coordination of Benefits Form](#)
- [Preventive Care](#)
- [Integrated Health Programs](#)

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

UVMHN 250 & UVMHN 400 PLAN

You must designate a Primary Care Physician (PCP), if you enroll in the 250 or 400 Plan, however, you may go outside of the provider network for health care services. You will pay less if you use doctors, hospitals, and other health care providers that belong to the BCBS Network.

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

UVMHN 1500 & 3000 HDHP WITH HSA

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

The UVMHN HDHP with HSA - 1500 and 3000 Plans, require all services with the exception of preventive care visits and some preventive medication, apply toward the deductible and coinsurance. There are no co-pays on this plan. This means if you have a doctor's visit or need a prescription that is not considered preventive, the cost of the visit and the script would apply towards the deductible.

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

EMBEDDED VS. AGGREGATE DEDUCTIBLE

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

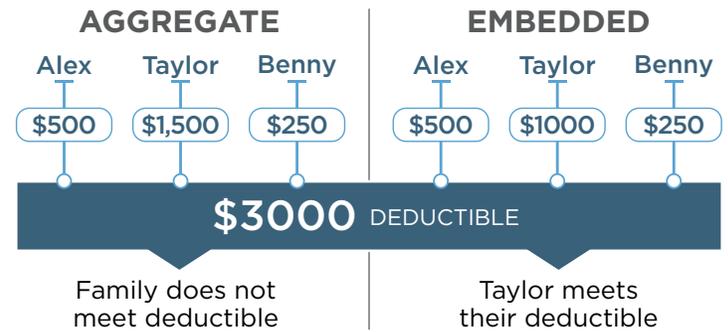


FITZ FAMILY:

- \$3,000 Deductible

MEDICAL BILLS THIS YEAR:

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



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

Notes: All plans provide cross-accumulation of in and out of network deductibles and coinsurance.

BENEFIT PLAN	UVMHN 250 & 400 Plan			UVMHN HDHP with HSA - 1500 & 3000 Plan		
For Deductible and Out-of-Pocket Information, please see page 10.						
Network	UVMHN Providers	BCBS National Providers & Non-UVMHN Providers	Out-of-Network Providers	UVMHN Providers	BCBS National Providers & Non-UVMHN Providers	Out-of-Network Providers
General Medical Expenses						
Preventive Care (includes annual physical and other age-based screenings)	100% covered			100% covered		
Primary Care Office Visit	100% covered	\$10 co-pay	After deductible, 30% coinsurance, up to out of pocket max	10% after deductible, up to out-of-pocket max	20% after deductible, up to out-of-pocket max	30% after deductible, up to out-of-pocket max
Outpatient Mental Health & Substance Use Visit						
Specialist Office Visit	\$25 co-pay					
Chiropractic Care/Acupuncture (combined 12 visit limit per calendar year)						
Maternity Office Visits	\$10 co-pay	\$25 co-pay	Any scans or sonograms require deductible and coinsurance.			
Outpatient Care						
Outpatient Physical, Speech, Occupational Therapy	100% covered	\$25 co-pay	30% after deductible, up to out-of-pocket max	10% after deductible, up to out-of-pocket max	20% after deductible, up to out-of-pocket max	30% after deductible, up to out-of-pocket max
Outpatient Lab and X-ray		10% after deductible, up to out-of-pocket max				
Outpatient CT/MRI/Nuclear Scans						
Outpatient Surgery						
Physician and Facility Fees	5% after deductible, up to out-of-pocket max					
Emergency Services						
Emergency Room Facility	\$50 co-pay (waived if admitted)			10% after deductible, up to out-of-pocket max	20% after deductible, up to out-of-pocket max	30% after deductible, up to out-of-pocket max
Urgent Medical Care	\$25 co-pay					
Inpatient						
Hospitalization (includes maternity delivery & newborn services, labs and scans)	5% after deductible, up to out-of-pocket max	10% after deductible, up to out-of-pocket max	30% after deductible, up to out-of-pocket max	10% after deductible, up to out-of-pocket max	20% after deductible, up to out-of-pocket max	30% after deductible, up to out-of-pocket max
Residential Treatment Facility (mental disorders, alcoholism, or drug abuse)						
Other Benefits						
Routine Eye Exam (1 visit every 2 calendar years)	100% covered must use VSP Provider		not covered	100% covered must use VSP Provider		not covered
Infertility Treatment: AI, IUI, IVF (Lifetime max of \$15,000)	50% coinsurance	not covered		50% coinsurance	not covered	

BCBSVT & BCBS National Participating providers will:

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

Prescription Coverage

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

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

PHARMACY NETWORK

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

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

COVERAGE

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

BENEFIT PROVIDED BY:
Navitus Health Solutions

CONTACT INFORMATION:
(866) 333-2757

GROUP NUMBER:
NVUVM

WEBSITE:
Navitus.com

ONLINE ACCESS:

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

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

OTHER HELPFUL INFORMATION:

- [Preventive Drug List](#)
- [Navitus Formulary](#)
- [Member Claim Form](#)
- [UVM Health Network Pharmacy App](#)

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

NOTE:

SEPARATE ID CARDS ARE ISSUED BY BCBSVT AND NAVITUS.

UNDER THE 1500 HDHP AND 3000 HDHP, YOU WILL BE RESPONSIBLE FOR THE COST OF ANY CARE, SERVICES, OR PRESCRIPTIONS UP TO THE DEDUCTIBLE. AFTER MEETING THE DEDUCTIBLE, YOU WILL PAY COINSURANCE FOR MEDICAL CARE AND SERVICES. A CO-PAY WILL APPLY FOR ANY PRESCRIPTIONS AFTER THE DEDUCTIBLE IS MET.

EXAMPLE:

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

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

EXAMPLE:

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

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

EXAMPLE:

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

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

PREVENTIVE DRUG LIST

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

SPECIALTY PRESCRIPTIONS

EXCLUSIVELY FILLED AT UVMHN SPECIALTY PHARMACY

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

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

MEDICATION MANAGEMENT SERVICES

UVMHN has partnered with Vanderbilt Health Rx Solutions to make Medication Management Services available to you. These services are personalized to individual needs and help manage complex medications. Medication Management Services can:

- **Provide answers to your medication questions**
- **Improve your health by making sure your medicines are safe and working well for you**
- **Increase coordination between you, your healthcare team, and a clinical pharmacist**

Employees who are taking several medications or who have complex needs may receive a phone call from the Vanderbilt Health Pharmacy team.

Spending and Savings Accounts

FSA & HSA



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

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

FLEXIBLE SPENDING ACCOUNT GENERAL, LIMITED PURPOSE AND DEPENDENT CARE

OVERVIEW & ELIGIBILITY

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

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

USING THE MONEY

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

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

BENEFIT PROVIDED BY:

HealthEquity
(formerly WageWorks)

CONTACT INFORMATION:

(877) 924-3967

GROUP NUMBER:

26018

WEBSITE:

healthequity.com

PLANS OFFERED:

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

CONTRIBUTIONS:

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

UVMHN provides employer contributions for the HSA

OTHER HELPFUL INFORMATION:

- [Eligible Expenses](#)
- [FSA Guide](#)
- [Dependent Care Guide](#)
- [Investing your HSA](#)

GENERAL PURPOSE FSA ELIGIBLE EXPENSES

Pre-tax funds can be used for:

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

CARRYOVER BENEFIT - GENERAL & LIMITED PURPOSE FSA

You may carryover up to \$550 of unused funds into the next plan year. The carryover amount doesn't count towards your annual contribution maximum. Any unused funds greater than \$550 will be forfeited after the last day of the run-out period. The run-out period (January 1–May 31) provides you additional time to submit claims that were incurred during the plan year for reimbursement. If you have more than \$550 in your account at the end of the year, you will lose it.

EXAMPLE:

Let's say you have \$800 remaining at the end of the plan year (December 31, 2020). You have until May 31, 2021 to submit for any expenses incurred in 2020. If you do not have any expenses from 2020, \$550 will carry over into the next plan year (2021). The remaining \$300 will not carry over.

LIMITED PURPOSE FSA ELIGIBLE EXPENSES

Pre-tax funds can be used for:

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

LIMITED PURPOSE FUNDS CANNOT BE USED FOR MEDICAL EXPENSES.

CONTRIBUTIONS - GENERAL & LIMITED PURPOSE FSA

General and Limited Purpose FSAs allow you to contribute up to \$2,750, in 2021, for eligible expenses for you, your spouse, and/or any eligible dependents.

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

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

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

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

OVERVIEW & ELIGIBILITY

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

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

DEPENDENT CARE FSA ELIGIBLE EXPENSES

PRE-TAX FUNDS CAN BE USED FOR:

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

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

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

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

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

CONTRIBUTIONS - DEPENDENT CARE

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

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

GRACE PERIOD - DEPENDENT CARE

While there is no carryover for Dependent Care FSA, there is a grace period. The grace period provides additional time for you to use the funds remaining in your account. You have until March 15, 2022 to incur expenses that can be paid for using funds remaining from the 2021 plan year.

EXAMPLE:

If you have \$300 remaining at the end of the plan year (December 31, 2020). Those funds will remain available for you to use for eligible expenses until March 15, 2021.

You have until May 31, 2021 to submit those 2020 eligible expenses for reimbursement.

Health Savings Account

(HSA)

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

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

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

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

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

CONTRIBUTIONS

In 2021, UVMHN will make a contribution to your HSA help you lower your out-of-pocket costs and save more. Then, you can make pre-tax contributions from your paycheck to build your savings to pay for health care now or in the future. The UVMHN HSA contribution is based on the plan you choose and who you cover. UVMHN's contribution and your HSA savings are always yours to keep or use toward health care expenses.

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

See the [Appendix](#) for more details.

HSA CONTRIBUTION LIMITS	UVMHN HDHP with HSA Plan - 1500		UVMHN HDHP with HSA Plan - 3000	
	Single	Family	Single	Family
UVMHN Contribution	\$500	\$1,000	\$1,000	\$2,000
Your Contribution	Up to \$3,100	Up to \$6,200	Up to \$2,600	Up to \$5,200
Total Contribution allowed by the IRS	\$3,600	\$7,200	\$3,600	\$7,200

If you will be 55+ by end the of the calendar year, you can contribute an additional \$1,000 to the total noted above.

ENROLLMENT

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

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

DO YOU QUALIFY?

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

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

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

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

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

ELIGIBLE EXPENSES

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

Examples of eligible expenses include:

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

USING YOUR ACCOUNT

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

INVESTMENT OPTIONS

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

HOW AN HSA HELPS YOU SAVE FOR RETIREMENT

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

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

AS AN HSA OWNER, YOU:

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

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

SPENDING AND HEALTH SAVINGS ACCOUNT OVERVIEW

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

SPENDING AND HEALTH SAVINGS ACCOUNT OVERVIEW

	General Purpose FSA	Limited Purpose FSA	Health Savings Account	Dependent Care FSA
Calendar Year Contribution Limits	From \$150 to \$2,750		Single: \$3,600 Family: \$7,200 \$1,000 catch-up contribution for anyone 55 or older Limit includes any UVMHN contributions made to your account.	From \$150 to \$5,000 for individuals, married couples filing jointly. The limit is \$2,500 for a married person filing separately.
When is the money available for me to use for expenses?	Immediately		UVMHN will make contributions to your account 4 times per year. You have access to the amount you have contributed through payroll deductions.	Contributions are added to your account after each payroll deduction. You have access to the amount you have contributed through payroll deductions.
Who makes contributions?	You		UVMHN and You	You
Do I have the ability to make changes to my contribution mid-year?	No, unless you have a qualifying life event or at annual open enrollment.		Anytime.	No, unless you have a qualifying life event or at annual open enrollment.
Can I invest my contributions?	No		Yes, once your balance reaches \$1,000.	No
What are the eligible expenses under these plans?	Medical, Prescription, Dental and Vision Expenses	Dental and Vision Expenses	Medical, Prescription, Dental and Vision expenses, and some insurance premiums such as COBRA and Medicare.	Child or Elder care while you are at work.
	Complete list available via IRS.gov , under Publication 502.			Complete list available via IRS.gov , under Publication 503.
When do I have to incur expenses?	January 2021 - December 2021		There is no deadline to incur or submit an expense. Just submit a claim whenever you would like to reimburse yourself. You own the account, so the money does not need to be used within any timeline.	January 2021 - March 15, 2022
If I have unused money at the end of calendar year, what happens?	You are allowed to carry over up to \$550 of unused balance to the following plan year. Anything above \$550 is forfeited.			If you have unused funds after March 15, 2022, they will be forfeited.
When do I have to submit expenses by in order to not lose any money?	May 31, 2022			May 31, 2022
What happens if I switch employers or retire?	You have until the last day of employment to incur expenses. If you have unused money, you can choose to elect Cobra to extend your time to incur expenses, or you would forfeit those funds.			You have until the last day of employment to incur expenses. If you have unused money, you forfeit those funds.

Dental Coverage

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



NETWORK

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

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

UTILIZING A NON-PARTICIPATING PROVIDER

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

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

ENROLLMENT AND UTILIZING COVERAGE

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

PREDETERMINATION OF BENEFITS

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

BENEFIT PROVIDED BY:
Northeast Delta Dental

CONTACT INFORMATION:
(800) 284-6630

8:30am -5pm
MONDAY - FRIDAY

GROUP NUMBER:
7407

WEBSITE:
nedelta.com

PLANS OFFERED:

- Core
- Buy-up

COVERAGE LEVELS:

- 1 Person
- 2 Person
- Family

PREMIUMS:

- [Cost Share](#) – You and UVMHN
- Pre-tax from your paycheck

OTHER HELPFUL INFORMATION:

- [Outline of Coverage](#)
- [Summary Plan Description](#)
- [Double-up Maximum Carryover Benefit](#)
- [Health through Oral Wellness Pocket Guide](#)
- [Vision & Hearing Discounts through Delta Dental](#)
- [Website Overview](#)

DENTAL COVERAGE OVERVIEW

BENEFIT PLAN	Description	Core	Buy-up
WAITING PERIOD	There is no waiting period for services. Coverage is effective on the first day your coverage becomes active.		
NETWORK	2 Networks of Providers: PPO - Dentists who have agreed to accept reduced fees for covered services, in turn minimizing your out-of-pocket expenses. Premier - Dentists under a fee-for-service arrangement, providing the largest network of dentists.	Delta Dental PPO Plus Premier	
DEDUCTIBLE	Applies to Coverage B & C noted below.	\$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%
BASIC (COVERAGE B)	Fillings, routine extractions, root canal, treatment of gum disease, denture repair	80%	80%
MAJOR (COVERAGE C)	Crowns, dentures, implants, surgical extractions, removable and fixed partial dentures(bridge)	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.	\$1,500	\$1,500
DOUBLE - UP MAX BENEFIT MAXIMUM	During a calendar year, if you have less than \$500 in claims and receive an oral exam/cleaning, then \$250 will carry over and be available for use in future years.	Up to \$3,000	Up to \$3,000
ORTHODONTICS COVERAGE	Provides coverage for dependent children and adults	50%	65%
LIFETIME MAXIMUM FOR ORTHODONTICS	Per person enrolled under the plan.	\$1,500	\$2,500

HEALTH THROUGH ORAL WELLNESS (HOW)

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

FOR MORE INFORMATION AND TO REGISTER, VISIT [HEALTHTHROUGHORALWELLNESS.COM](https://www.healththroughoralwellness.com).

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

Vision Coverage



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

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

PROVIDERS

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

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

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

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

ADDITIONAL DISCOUNTS:

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

BENEFIT PROVIDED BY:
Vision Service Plan

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

GROUP NUMBER:
12157661

WEBSITE:
vsp.com

PLANS OFFERED:

- Core
- Buy-up

COVERAGE LEVELS:

- 1 Person
- 2 Person
- Family

PREMIUMS:

- [Paid for by you](#)
- Pre-tax from your paycheck

OTHER HELPFUL INFORMATION:

- [Outline of Coverage](#)
- [Summary Plan Description](#)
- [Additional Discounts](#)
- [TruHearing](#)

COVERAGE OUTLINE

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

VISION COVERAGE OVERVIEW

NETWORK	VSP Signature			
	Regardless of plan selected - you must select glasses or contacts. You cannot receive both.			
BENEFIT PLAN	Core		Buy-up	
	Cost	Frequency	Cost	Frequency
EXAM	\$20 co-pay	Every Calendar Year	\$10 co-pay	Every Calendar Year
FRAMES	\$130 allowance \$150 allowance for featured frame brands 20% discount on any amount over allowance	Every Other Calendar Year	\$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 GLASSES)	\$130 allowance for contacts and contact lens exam	Every Calendar Year	\$175 allowance for contacts and contact lens exam	Every Calendar Year
LENS ENHANCEMENT COVERAGE	Progressive Lenses	\$0 - \$160	Progressive Lenses	\$0 - \$160
	Discounts on scratch resistance, anti-glare, and tinted lenses	35% - 40%	Discounts on scratch resistance, anti-glare, and tinted lenses	35% - 40%

Wellness

LIVING WELL FOR LIFE.

We want employees to be engaged in their jobs and communities, be active and engaged in their physical health and ultimately achieve their highest level of well-being.

The Living Well for Life Committee is a team of Porter Medical Center employees that are passionate about “living well”! Our mission is to educate and engage employees and volunteers through comprehensive and focused programs and initiatives, that support optimal health and wellbeing through the creation, implementation, and review of Porter’s annual wellness strategic plan.

The Living Well for Life Team will continue to offer fun and educational opportunities for employees to improve their daily wellness. Keep your eye on the Porter Pipeline, Intranet page and your email inbox for activities throughout the year!



ACCORDING TO RESEARCH

- 66% of are doing well in at least 1 area
- Only 7% are thriving in all areas.

GET THE MOST OUT OF EVERYDAY LIFE BY BOOSTING YOUR STRENGTHS IN ALL FIVE AREAS.

Life Insurance



TERM LIFE INSURANCE

Benefit eligible employees are provided, at no cost, one time your annual earnings in term life insurance, up to \$500,000. This coverage includes Accidental death and dismemberment (AD&D) which provides financial coverage if there is an unintentional death or dismemberment (loss of use of body parts or functions). Refer to the Summary Plan Description (SPD) for more specific information. You are automatically enrolled in coverage the first of the month following 90 days of employment or your benefit eligibility date. There are no health requirements or questionnaires for employer provided coverage.

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

EXAMPLE OF EMPLOYER PAID LIFE INSURANCE:

Hourly Rate: \$15.00

Bi-weekly Authorized Hours: 80 hours

$\$15.00 \times 80 \text{ hours} \times 26 \text{ pay periods} = \$31,200$

Annual Salary is then rounded to nearest thousand = \$32,000

In this example, you would be provided \$32,000 in term life insurance that would be paid out in the event of their death.

LIFE INSURANCE AND INCOME TAXES

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

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

BENEFICIARY DESIGNATION

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

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

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

CARRIER:

The Hartford

CONTACT INFORMATION:

(888) 716-4549

POLICY NUMBER:

OGL889094

WEBSITE:

TheHartfordatWork.com

ADDITIONAL COVERAGE OPTIONS

In addition to the term life coverage provided to you, you can purchase additional life coverage under UVM Health Network's group policy through The Hartford.

YOU HAVE THE OPTION TO PURCHASE:

- Additional Employee Life
- Spouse Life
- Child Life

LIFE INSURANCE PAYMENTS

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

ADDITIONAL EMPLOYEE LIFE INSURANCE

Additional Life Insurance coverage for yourself can be purchased in increments of \$10,000, up to a maximum of \$500,000, not to exceed five times your annual earnings. This maximum includes the employer paid coverage.

- **Additional life insurance coverage provides you accidental death and dismemberment coverage automatically and mirrors the value of the term coverage as long as the value is the lesser of five times your annual salary or \$500,000.**
 - Accidental death and dismemberment (AD&D) coverage provides financial coverage if there is an unintentional death or dismemberment (loss of use of body parts or functions). Refer to the Summary Plan Description (SPD) for more specific information.
- **Rates are age-banded and adjust within the pay period of your birthday.**
- **Additional benefits under your coverage are Seat Belt and Air Bag Coverage, Repatriation, Child Education benefits. Refer to the Summary Plan Description (SPD) for more information.**

SPOUSE LIFE INSURANCE

You can elect to purchase additional coverage for your spouse in increments of \$5,000 up to \$250,000. Coverage provides term coverage as well as accidental death and dismemberment coverage.

- **Any coverage you elect on your spouse cannot exceed the coverage you have on yourself, which can be a combination of employer and optional coverage.**

CHILD LIFE INSURANCE

Life Insurance for dependent children can be purchased for children up to age 26. Coverage provides an option of \$1,000, \$5,000, \$10,000, or \$15,000 benefit for each dependent child from live birth up to the age of 26. No EOI is required for child life insurance.

FOR AGE-BANDED RATES AND PREMIUM CALCULATION, PLEASE SEE THE [APPENDIX](#).

EVIDENCE OF INSURABILITY

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

- **EOI will be emailed to your work address following enrollment in Workday.**
- **EOI must be completed within 60 days.**
- **The Hartford will notify you of approval or denial.**
- **Premiums will be deducted from your paycheck and coverage will be visible within Workday.**

AGE REDUCTION

Under The Hartford life insurance policies there is a reduction in life insurance coverage once you reach the age of 70. Your coverage continues; however this means the insurance coverage is reduced by a certain percentages based on your age. This reduction applies to UVM Medical Center paid coverage as well as any optional coverage you elect for you or your spouse. The reduction is based upon the insured person's date of birth.

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

PORTABILITY/CONVERSION

If you leave UVM Health Network employment or become employed in an ineligible status, you can take the coverage with you. Under The Hartford Life Insurance Plans, you can take your coverage with you by porting or converting coverage.

If you terminate employment or become ineligible for coverage, you will be notified by The Hartford via USPS mail on your options and steps necessary to continue coverage. Please be aware you have 31 days to make an election on continuation.

Short-Term Disability

(STD)

Short-term disability (STD) is available through The Hartford to full-time and part-time active employees who work at least 20 hours per week. Coverage begins, if elected, the first of month following 90 days of employment.

COVERAGE

Coverage begins upon completing and signing a group insurance enrollment form and delivering it to Porter Medical Center Human Resources. STD provides the employee a portion of their pay when they are out of work for approved non-occupational illnesses/injuries or pregnancy. Employees must contribute to the cost of coverage. Cost for coverage is \$0.708 per \$10 of weekly benefit coverage.

- If you are disabled due to an injury, benefits commence on the day of Total Disability or Disabled and Working.
- If you are disabled due to an illness, benefits commence on the 8th day of Total Disability of Disabled and Working.

The weekly benefit provided is the lesser of 60% of your pre-disability earnings or \$1,250, reduced by other income.

The maximum length of the STD benefits is 13 weeks for Disability caused by injury or sickness.

REASONS WHY YOU MIGHT NEED DISABILITY

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

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

STARTING A CLAIM

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

Things you should do before a leave:

- Learn about the Leaves available for you
- Make your request to your manager in person, if possible
- Call The Hartford



BENEFIT PROVIDED BY:

The Hartford

CONTACT INFORMATION:

(888) 716-4549

GROUP NUMBER:

697296

WEBSITE:

TheHartfordatWork.com

WEBSITE FEATURES:

- Start a Claim
- Check Claim Status

PLANS OFFERED:

- Short-term Disability
- Long-term Disability

PREMIUMS:

- Paid by You and Porter

OTHER HELPFUL INFORMATION:

- [BCBS Better Beginnings](#)

MATERNITY LEAVE

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

Long-Term Disability

(LTD)

Long-term disability (LTD) is available through The Hartford to full-time and part-time active employees who work at least 20 hours per week. Coverage begins the first of month following 90 days of employment.

LTD insurance provides 60% of an employee's base monthly salary on the date of the approved disability. Maximum monthly benefit is \$6,000. LTD coverage is provided at no cost to you.

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

A registered nurse case manager will work with you and your provider to promote healthy outcomes for you and your baby. You will also receive some benefits like reimbursement for educational classes, fitness classes, car seat, or homemaker. You will also receive a voucher for a personal-use breast pump. Enroll prior to 34 weeks pregnant.

Visit bcbsvt.com for more information.

403(b) Retirement Plan



PLAN HIGHLIGHTS

- Employees can contribute to the plan immediately by way of Traditional pretax deferrals and Roth after-tax deferrals.
- Automatic enrollment applies upon hire or rehire. Your deferral will be set to a 2% pretax employee deferral. You may opt out of auto-enrollment or choose other deferral amounts.
- If you were hired on or after January 1, 2020 you will be enrolled in the annual automatic pre-tax deferral increase program. Your pre-tax deferral will increase by 1% per year, up to a maximum of 10% of pay, unless you elect a different deferral percent or stop your pre-tax deferrals.
- You may contribute 1% - 75% of your eligible pay, up to the IRS allowed limit. You can change your contribution percentage at any time.
- In general, if you are age 21 or older and work 1,000 or more hours in the year, you will be eligible for an annual non-elective contribution from Porter Medical Center. You do not need to be contributing to the Plan to receive the annual contribution and you do not need to be employed at the time the contribution is made.
- The amount of the annual contribution from Porter Medical Center varies from 3% - 6%, based on how many Years of Service you have.
- You direct how to invest your contributions. If you make no election, contributions will go to a default investment option based on your age.
- You are always 100% vested in your personal contributions and the earnings on your contributions.
- Annual Porter Medical Center contributions are subject to a tiered vesting schedule. With each Year of Service for vesting you earn, you become 20% vested. You are 20% vested with one year, 40% vested with two years, and eventually 100% vested when you've earned your fifth year of vesting service.
- Contact Fidelity or use their website to manage your contribution amount and your investment selections.

PARTICIPATION

All employees can participate in the 403(b) Retirement Plan immediately. Generally, accounts for new employees are established within the first week of employment.

You may change your contribution amount at any time.

BENEFIT PROVIDED BY:

Fidelity

CONTACT INFORMATION:

FIDELITY RETIREMENT
SERVICE CENTER

(800) 343-0860

FIDELITY MEETING RESERVATIONS

(800) 642-7131

GROUP NUMBER:

69524

WEBSITE:

[nb.fidelity.com/public/
nb/UVMHealth/home](https://nb.fidelity.com/public/nb/UVMHealth/home)

RETIREMENT PLAN:

403(b)

CONTRIBUTIONS:

Cost Share - You and UVMHN

Pre-tax or Post-tax
from your paycheck

OTHER HELPFUL INFORMATION:

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

ENROLLMENT, AUTOMATIC ENROLLMENT & OPTING OUT

You may begin contributing to the plan at any time. **If you do not take any action, you will be automatically enrolled into the 403(b) Retirement Plan upon being hired or rehired.** The pre-tax contribution will be set at 2% of pay. Automatic enrollment applies to all new employees and rehires regardless of employment status (full-time, part-time, per diem).

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

1. While using the Porter network, log on to NetBenefits.com/easy. Click Register as a New User and follow prompts to establish a user name and password. You will need a code that will be sent to your work email account.
2. Call Fidelity at (800) 343-0860.

If you already have an account at Fidelity, use your existing username and password, then proceed to The Porter Medical Center 403(b) Plan from your dashboard.

EMPLOYEE CONTRIBUTIONS

YOUR CONTRIBUTIONS

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

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

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

YOUR CONTRIBUTION LIMIT

In 2021, the IRS contribution limit is \$19,500.

If you will be 50 or older in 2021, you may make additional catch-up contributions of \$6,500. For your convenience, if you meet the age requirement, your contribution limit will be automatically extended to \$26,000 for the year.

The IRS typically announces contribution limits each November.

Porter Medical Center will automatically shut off your contributions when you hit the allowed maximum for your age.

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

EMPLOYER CONTRIBUTIONS & VESTING

In general, if you are age 21 or older and work 1,000 or more hours in the calendar year, you will be eligible for an annual contribution from Porter Medical Center. You do not need to be contributing to the Plan to receive the annual contribution, nor must you be employed at the time the contribution is made.

The amount of the annual contribution from Porter Medical Center varies from 3% - 6%, based on how many Years of Service you have.

YEARS OF SERVICE AND PORTER EMPLOYER CONTRIBUTIONS:

- 0-9 YOS = 3%
- 10-19 YOS = 4%
- 20-29 YOS = 5%
- 30+ YOS = 6%

A Year of Service is measured as the number of consecutive 12-month periods of employment you had as of your hire date anniversary in the plan year. There is no hours requirement.

The employer contribution is made annually, typically by the end of March for the previous calendar year.

See the Summary Plan Description for more information.

VESTING

Employer contributions are subject to vesting service requirements. “Vesting” refers to your ownership of employer contributions. Porter Medical Center uses a tiered vesting schedule for its employer contributions. As you accumulate Years of Service for vesting, the percentage of employer contributions that you own increases. After reaching 5 years of vesting service, you become fully vested.

VESTING SCHEDULE FOR PORTER EMPLOYER CONTRIBUTIONS, BASED ON YEARS OF SERVICES:

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

A Year of Service for vesting purposes is a plan year in which you work 1,000 or more hours.

Accelerated vesting applies in the case of death or disability while actively employed.

INVESTMENT OPTIONS

Our plan offers a wide range of investment options designed to meet your specific goals, time horizon and risk tolerance. There are mutual funds for stocks, bonds, and short-term investments such as money markets and US Treasuries. The investment line-up also includes age-based, target date mutual funds.

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

If you do not make investment elections, contributions will be automatically invested in the Plan's predetermined default account. UVM Health Network has selected the T. Rowe Price Target Retirement Life Cycle Funds to serve as the default. Which fund you would default to depends on your age and expected retirement date.

REHIRE & SERVICE TIME INFORMATION

If you previously worked at Porter Medical Center and are re-hired, you may be eligible to keep your Years of Service from your earlier employment period. If your break-in-service was shorter than the length of time you previously worked at Porter, you will retain your Years of Service for the purposes of determining the percentage of employer contributions you are eligible for.

If you worked at Porter or any UVMHN affiliate within the past five years and have been rehired, your earlier service time will apply to the 6-month wait for employer contributions and the three year vesting period. Please contact the Benefits Department if you believe this may apply to you.

EDUCATION & CONSULTATIONS

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

LEARN MORE & MANAGE

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

BENEFICIARIES

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

RECEIVING MONEY FROM YOUR ACCOUNT

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

- **You experience a financial hardship**

For more information, please see the Summary Plan Description.

Hospital Indemnity Voluntary Insurance



The Hospital Indemnity plan is a voluntary plan that pays a cash benefit directly to you if you or a covered dependent is admitted into the hospital under the advice of a physician and you receive a bill for room and board. Hospital Indemnity Insurance is not meant to be a replacement for your medical insurance.

UVM Health Network has partnered with Voya, a leading voluntary insurance provider, to bring a Hospital Indemnity Insurance Plan to you and your eligible family members. **Hospital Indemnity Insurance provides a fixed daily cash payment if you or a covered family member have a covered stay* in a hospital, critical care unit, or rehabilitation facility.**

SOME THINGS YOU COULD USE THE PAYMENT FOR ARE:

- Deductible or coinsurance
- Childcare expenses
- Mortgage/rent
- Everyday expenses like utilities and groceries
- Travel, food, and lodging

SOME FEATURES OF HOSPITAL INDEMNITY INSURANCE ARE:

- **Guaranteed Issue** - No medical questions or tests are required for coverage.
- **Flexible** - Ability to use the money how you would like.
- **Portable** - Ability to keep your coverage if you leave or retire from UVM Health Network.
- **Lower Premiums** - The cost of the plan is less because of the group purchasing power and the cost of the coverage is conveniently taken as a payroll deduction.

*Covered Stay refers to an admission or confinement within a qualified institution that is run for the care of treatment of sick or injured persons AND such admission and confinement is at the advice of a physician in which a room and board charge is issued. Please refer to your Certificate of Coverage for more information.

BENEFIT PROVIDED BY:

Voya

CONTACT INFORMATION:

(877) 236-7564

GROUP NAME:

UVM Health Network

POLICY NUMBER:

71746-6

WEBSITE:

[Presents.voya.com/
EBRC/UVMHN](https://presents.voya.com/EBRC/UVMHN)

PLANS OFFERED:

- **CORE**
\$100 Daily Benefit
- **BUY-UP**
\$200 Daily Benefit

COVERAGE LEVELS:

- Employee
- Employee & Spouse
- Employee & Child(ren)
- Family

PREMIUMS:

- [Coverage](#) is Paid for by you
- After-tax from your paycheck

OTHER HELPFUL INFORMATION:

- [Outline of Coverage](#)
- [How to File a Claim](#)

WHO CAN YOU COVER UNDER HOSPITAL INDEMNITY COVERAGE?

- Yourself
- Your Spouse/Civil Union Partner
- Your legally dependent children up to age 26
- A newborn child
 - When existing child coverage is effective prior to birth, benefits for newborns are the same as for any other child
 - When child coverage is not effective prior to birth, a one-time benefit of \$100 is payable for the newborn child's confinement due to birth. No admission benefit is payable.

You, the employee, are required to be enrolled in order to cover a spouse and/or any children.

You do not need to be enrolled in the Porter insurance plans in order to enroll into this plan. You are eligible to enroll in the voluntary hospital indemnity plan even if you are covered by another health plan.

HOSPITAL INDEMNITY COVERAGE OVERVIEW	
Are there any medical questions or tests required in order to enroll in coverage?	No
Do I or my family need to be enrolled in UVM Health Network Medical coverage to enroll in Voya Hospital Indemnity?	
Is this a medical insurance policy?	No, this is a supplemental policy.
Does this coverage meet the minimum essential coverage under the Affordable Care Act?	
Is there a limit to how many times this benefit can be paid within a calendar year?	Yes, up to 8 times per covered person.

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

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

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

Pet Insurance

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

Pet parents have two Nationwide Insurance plans (Pet Protection and Pet Protection with Wellness) to choose from and 3 levels of reimbursement (90%, 70%, and 50%). Plan prices for UVMHN employees include a 5% discount; if you have multiple pets, you may qualify for discounts of up to 15%.* The cost of the plans is not based on pet age or breed, but rather plan, reimbursement and state in which you reside.

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

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

ENROLLMENT

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

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

NATIONWIDE PET INSURANCE			
Plan	Deductible	Reimbursement Options	Annual Maximum
MY PET PROTECTION	\$250	90% 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			
MY PET PROTECTION WITH WELLNESS	\$250	90% 70% Or 50%	\$7,500
Everything noted under My Pet Protection plus: Wellness exams, vaccinations, spay/neuter, flea/tick prevention, heartworm testing/prevention, and routine blood tests			

BENEFIT PROVIDED BY:
Nationwide

CONTACT INFORMATION:

Enrollments
(877) 738-7874

Customer Care
(800) 540-2016

GROUP NAME:

The University of Vermont Health Network

WEBSITE:

petsnationwide.com

PLANS OFFERED:

- My Pet Protection
- My Pet Protection with Wellness

REIMBURSEMENT LEVELS:

- 90%
- 70%
- 50%

ENROLLMENT & PREMIUMS:

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

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

OTHER HELPFUL INFORMATION:

- [Pet Insurance Infographic](#)
- [FAQ's - Pre-enrollment](#)
- [FAQ's - Getting the most from your plan after enrollment](#)
- [FAQ's - Claim Reimbursement](#)
- [FAQ's - Vitus Mobile App](#)
- [Vethelpline®](#)

Allstate Identity Protection



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

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

FEATURES OF THE PLAN INCLUDE:

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

GETTING STARTED

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

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

COVERAGE CONTINUATION

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

BENEFIT PROVIDED BY:
Allstate Identity Protection

CONTACT INFORMATION:

Phone
(800) 789-2720

Email
clientservices@PrivacyArmor.com

GROUP NAME:
806

WEBSITE:
myaip.com/uvmhhealthnetwork

PLAN OFFERED:

- Identity Protection Pro

COVERAGE LEVELS:

- Employee
- Employee & Family

PREMIUMS:

- [Paid for by you](#)
- After-tax from your paycheck

OTHER HELPFUL INFORMATION:

- [Outline of Coverage](#)

Combined Time Off

(CTO)



Porter Medical Center provides benefits eligible employees with Combined Time Off (CTO) to cover periods of absence. CTO time may be used to cover an employee's absence for vacation time, sick time, and/or holiday time in which the employee is absent from work.

All employees scheduled to work 16 hours per pay period or greater in each bi-weekly pay period are eligible to accrue CTO. Per diem and temporary employees are not eligible for CTO accruals. CTO may not be used during an employee's three month training period. However, managers may use their discretion for situations involving holidays falling within the first three months of employment.

New hire hourly employees will begin employment at Porter Medical Center with zero hours in their CTO banks. Full-time hourly employees (80 hours per bi-weekly pay period) will accrue 176 hours (22 days) of CTO time over their first year of continuous employment. Part-time employees will accrue a pro-rated equivalent of this number. Accrual of CTO are based on actual hours worked per bi-weekly pay period. CTO will not accrue for hours worked over 80 per bi-weekly pay period or during periods of unpaid absence.

THE FOLLOWING HOLIDAYS ARE RECOGNIZED:

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

CTO ACCRUAL TABLE FOR HOURLY EMPLOYEES

Years of Tenure (Completed)	CTO Accrual per Hour Worked	Maximum Annual CTO Accrual (Hours)	Maximum Amount of CTO Allowed in Employee Bank (Hours)
0	.0847	176	352
1	.0885	184	368
2	.0924	192	384
3	.0962	200	400
4	.1000	208	416
5	.1039	216	432
6	.1077	224	448
7	.1116	232	464
8	.1154	240	480
9	.1193	248	496
10	.1231	256	512
11	.1270	264	528
12	.1308	272	544
13	.1347	280	560
Accrual Freeze at 13 Years of Tenure	n/a	n/a	n/a

Requests for time off are to be presented to the employee's Department Manager in accordance with department specific policies and procedures. Final decisions regarding time off will be made by the Department Manager. Time off will be granted or denied using an employee's available CTO/EIR bank. Employees may not take time off using perceived future accruals.

Extended Illness Reserve

(EIR)

Porter Medical Center provides benefits eligible employees with Extended Illness Reserve hours to cover periods of absence. Paid hours may be substituted for unpaid time during a period of absence which includes only the following situations:

- **Personal Illness (non-Family Medical Leave and/or Vermont Parental and Family Leave Act qualified illness):**

Employees may access their EIR banks after using the appropriate number of CTO days in accordance with the following usage table

Tenure at Porter Medical Center	Required CTO Usage Before EIR Usage
3 months - 5 years	3 days
6 years - 10 years	2 days
More than 10 years	1 day

- **Family Medical Leave (FMLA) or Vermont Parental and Family Leave Act (VPFLA) qualified illness:**

Employees who experience a personal illness or a charged with caring for a qualified family member also meet eligibility requirements for FMLA and/or VPFLA may immediately access their EIR banks. FMLA/VPFLA paperwork must be received and reviewed by Human Resources to determine eligibility. In the event that employees fail to present appropriate FMLA/VPFLA paperwork to Human Resources, CTO and/or unpaid time will be used to cover the period of absence. EIR may be retroactively awarded to include dates spanning back up to one month before the date that the employee notified HR of the need, once all paperwork is received and processed by Human Resources

- **Vermont Short Term Family Leave Act:**

Eligible employees may use CTO or EIR for all absences to qualify for the Vermont Short Term Family Leave Act.

All employees scheduled to work 16 hours per pay period or greater in each bi-weekly pay period are eligible to accrue EIR. Per diem and temporary employees are not eligible for EIR accruals. EIR may not be used during an employee's three month training period. However, managers may use their discretion for situations involving holidays falling within the first three months of employment.

New hire hourly employees will begin employment at Porter Medical Center with zero hours in their EIR banks. Full time hourly employees (80 hours per bi-weekly pay period) will accrue 40 hours (5 days) of EIR time over their first year of continuous employment. Part time employees will accrue a pro-rated equivalent of this number. Accruals of EIR are based on actual hours worked per bi-weekly pay period. EIR will not accrue for hours worked over 80 per bi-weekly pay period or during periods of unpaid absence. EIR may not be "cashed in" and is a non-vested benefit.

Requests for time off are to be presented to the employee's Department Manager in accordance with department specific policies and procedures. Final decisions regarding time off will be made by the Department Manager. Time off will be granted or denied using an employee's available CTO/EIR bank. Employees may not take time off using perceived future accruals.

Also please see the following policy: [Time Off](#)

CTO Sell

Any full-time or part-time employee can sell 0.5, 1.0, and 1.5 hours each pay period of time during Open Enrollment. That value is then paid to the employee through the following year's 26 paychecks. The dollars flow into your paycheck as additional income.

CTO Cash-in

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

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

Leave of Absences

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:

- Understand what benefits are available to you
- Notify your manager of your need for leave with as much advance notice as possible.
- Call The Hartford to initiate a Leave

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 Leave of Absence, FMLA policy.

ELIGIBILITY FOR FML:

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

ENTITLEMENT:

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

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: www.thehartfordatwork.com. Employees may use CTO, EIR or unpaid time to cover time off during this leave. EIR may be accessed immediately without the use of CTO.

BONDING LEAVE

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

BENEFIT PROVIDED BY:
The Hartford

CONTACT INFORMATION:
(888) 716-4549

GROUP NUMBER:
697296

WEBSITE:
TheHartfordatWork.com

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

Phone
(802) 847-2825, option 1

Email
LOA@UVMHealth.org

VERMONT PARENTAL AND FAMILY LEAVE

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

- [Vermont Parental and Family Leave via VDOL](#)

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

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

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

To apply, notify your manager and contact The Hartford. The Hartford will provide an ADAAA Medical Assessment Form which you will need to have completed by your medical provider regarding your accommodation need.

VERMONT SHORT-TERM FAMILY LEAVE

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

WORKERS' COMPENSATION

Workers' Compensation protects the employee in the event that an employee is injured at work. All employees are protected in accordance with the Workers' Compensation laws of the State of Vermont.

IMMEDIATELY FOLLOWING AN ACCIDENT OR INJURY YOU SHOULD:

- Report the injury immediately, no matter how minor, to their Supervisor, acting Supervisor or Department Head.
- If an employee requires medical treatment or assessment should report to the Hospital Emergency Room unless seeing an off-site physician would be more expedient (as in the case of employees working at offsite physician practices.)
- The employee should complete an electronic incident report using the SQSS within 24 hours of the incident. Employee without access should request assistance from their supervisor or the Human Resources Department.
- An employee injured at work who is removed from work on physician's order may be eligible for lost time compensation through Workers' Compensation.

An employee who is injured while on duty may use EIR or CTO while out on Workers' Compensation for 1 -3 days that they would regularly have been scheduled to work. An employee may elect to supplement their Workers' Compensation benefits with accrued EIR and/or CTO up to 100% of their average gross wage (excluding overtime, if applicable) for up to six weeks.

It is expected that an employee who is covered by Workers' Compensation and is referred to a physician will abide by the recommendation of the physician for all of their life activities, both personal and professional. In the event of a physical bodily injury, in order to return to work, an employee must present a return to work recommendation's report completed by a physician. In the event that an employee is cleared to work in a capacity other than full-duty, the employee's supervisor and/or human resources will review any restrictions on a case-by-case basis. Depending on the employee's job description, and on work availability, a decision will be made regarding Porter's ability to offer work other than the employee's usual full-duty assignment.

An employee who is out of work due to a Workers' Compensation injury may also be placed on Family Medical Leave and/or Vermont Parental and Family Leave at the discretion of human resources if the employee's injury meets the definition of the law.

LEAVE OF ABSENCE FOR MILITARY SERVICE

Porter Medical Center employees who are placed on active duty through a branch of the United States Military will be provided with a leave of absence for the duration of their active duty service. Porter Medical Center follows all applicable state and federal laws including the Uniformed Services Employment and Re-employment Rights Act. Please contact Human Resources for details if you are notified of a pending active duty notification from your branch of the United States Military.

OTHER LEAVES OF ABSENCE

Porter Medical Center offers a variety of other leaves, both paid and unpaid.

- **Bereavement Leave**

Available to regular employees in order to facilitate the mourning process when an employee's close family member passes away. There are times when employees will need to mourn for persons not covered in the bereavement policy. In those situations, while paid time off is not available through the bereavement policy, employees may request a personal leave and utilize CTO time if available.

Bereavement Leave is paid leave granted to regular employees by their supervisor in the event of a death in the immediate family. Bereavement Leave is not charged to CTO and will not exceed 3 days.

Bereavement Leave is intended to allow employees time to travel to and attend family gatherings and services, including but generally not past the date of the funeral. Employees who need time off in excess of Bereavement Leave may elect to use CTO time.

Members of the immediate family include mother, father, wife, husband, domestic partner, civil union partner, son, daughter, brother, sister, grandparent (of employee or spouse), grandchild, mother-in-law, father-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law or other individual living in the same household as the employee.

Employees will receive regular base pay under this policy for those days in which they were scheduled to work. Porter Medical is open to considering exceptions to this policy only under very extenuating circumstances. Such exceptions must be approved in writing by the employee's Senior Manager (Vice-President) and the Manager of Human Resources.

- **Personal Leave of Absence**

In the case that an employee of Porter Medical Center requests a leave of absence but does not qualify for FMLA, VPFLA, the Vermont Short Term Family Leave Act or Military Leave, a Personal Leave of Absence should be requested.

All Personal Leaves are approved or denied by the Department Manager and the Vice President that oversees their department. All personal leave requests will be considered on a case by case basis using department staffing trends and the employee's expected return to work date as the

primary determinants. If the personal leave of absence is approved, employees are required to use all available CTO and EIR before moving to unpaid status. Please note that EIR may only be used during a personal leave of absence that is approved for the employee's health condition. EIR may not be access if the employee takes a personal leave of absence to care for a family member or any other non-health related reason. Denial of a personal leave of absence request may result in the termination of the employee's position at Porter Medical Center. All employees terminated for this reason may re-apply for employment at Porter Medical Center after being cleared for full duty work with no restrictions by their physician or healthcare practitioner.

- **Unpaid Time Off**

Employees are required to use all available paid time off from the applicable time off banks when absent from work unless they are on an approved FMLA/VPFLA leave. Employees who do not qualify for FMLA/VPFLA must request a personal leave of absence from their Department Manager and Vice President to take time off without pay. Employees who take unpaid time off without an approved FMLA/VPFLA or personal leave of absence are subject to disciplinary action up to and including termination of employment.

- **Jury Duty**

Employees called to serve on jury duty must present their Department Manager a copy of the summons. PMC will provide appropriate time off from work for employees to take part in jury duty. Employees must provide their department manager proof of attendance and compensation from the court after each session of jury duty. PMC, in combination with court compensation, will ensure the employee receives full pay for time missed from work without the use of CTO. In the case the court does not compensate the employee or the employee chooses to decline court compensation, PMC will pay the employee base wages for scheduled days missed due to jury duty service.

Employees who miss work due to jury duty are required to provide proof of attendance to their Department Manager within 5 business days after the scheduled date of attendance. Failure to provide appropriate documentation of attendance may result in disciplinary action.

- **Election to the State Legislature**

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

- **Unpaid Time Off**

Employees are required to use all available paid time off from the applicable time off banks when absent from work unless they are on an approved FMLA/VPFLA leave. Employees who do not qualify for FMLA/VPFLA must request a personal leave of absence from their Department Manager and Vice President to take time off without pay. Employees who take unpaid time off without an approved FMLA/VPFLA or personal leave of absence are subject to disciplinary action up to and including termination of employment.

To initiate a claim notify your manager and contact The Hartford.

Employee Assistance Program



ABILITY ASSIST COUNSELING SERVICES

GETTING SUPPORT SHOULD BE EASY.

Life presents complex challenges. If the unexpected happens, you want to know that you and your family have simple solutions to help you cope with the stress and life changes that may result. That's why the Hartford's Ability Assist Counseling Services, offered by ComPsych, can play such an important role. Our straightforward approach takes the complexity out of benefits when life throws you a curve.

ABILITY ASSIST COUNSELING SERVICES		
Emotional or Work-Life Counseling	Helps address stress, relationship or other personal issues you or your family members may face. It's staffed by GuidanceExperts SM — highly trained master's and doctoral level clinicians — who listen to concerns and quickly make referrals to in-person counseling or other valuable resources.	Situations may include: <ul style="list-style-type: none"> • Job Pressures • Relationship/marital conflicts • Stress, anxiety and depression • Work/school disagreements • Substance abuse • Child or elder care referral services
Financial Information and Resources	Provides support for the complicated financial decisions you or your family members may face. Speak by phone with a Certified Public Accountant and Certified Financial Planner TM Professionals on a wide range of financial issues.	Topics may include: <ul style="list-style-type: none"> • Managing a budget • Retirement • Getting out of debt • Tax questions • Saving for college
Legal Support and Resources	Offers assistance if legal uncertainties arise. Talk to an attorney by phone about the issues that are important to you or your family members. If you require representation, you'll be referred to a qualified attorney in your area with a 25% reduction in customary legal fees thereafter.	Topics may include: <ul style="list-style-type: none"> • Debt and bankruptcy • Guardianship • Buying a home • Power of attorney • Divorce
Health ChampionSM	A service that supports you through all of your aspects of your health care issues by helping to ensure that you're fully supported with employee assistance programs and/or work-life services. HealthChampion is staffed by both administrative and clinical experts who understand the nuances of any given health care concern.	Situations may include: <ul style="list-style-type: none"> • One-on-one review of your health concerns • Preparation for upcoming doctor's visits/lab work/tests/surgeries • Answers regarding diagnosis and treatment options • Coordination with appropriate health care plan provider(s) • An easy-to-understand explanation of your benefits—what's covered and what's not • Cost estimation for covered/non-covered treatment • Guidance on claims and billing issues • Fee/payment plan negotiation

SERVICE FEATURES

The service includes up to three face-to-face emotional or work-life counseling sessions per occurrence per year. This means you and your family members won't have to share visits.

GETTING IN TOUCH IS EASY

- **On the phone:** Just one simple call. For access over the phone, simply call toll-free 1-800-96-HELPS (1-800-964-3577).
- **Online:** The point is simplicity. You'll also have 24/7 access to GuidanceResources[®] Online (offered by ComPsych).

Tuition Advance Program

Porter Medical Center has established the Tuition Advance Program to facilitate and encourage employees' continued education in an effort to foster individual growth and development and to improve quality of skills and competence.

Tuition advance is available to regular full and part time employees with a scheduled status of 16 hours per two week pay period or more who have been continually employed at Porter Medical Center (PMC) for at least six months. Courses submitted to the Tuition Advance Program for payment must be of graduate, undergraduate or technical school level to be considered for payment. Courses must be deemed relevant to work performed at Porter Medical Center to qualify for advance funds. All courses must culminate with either a letter grade, pass/fail status or a certificate of completion.

Tuition expenses towards a professional certification within the employee's current field of work will qualify for the Tuition Advance Program only when said employee voluntarily seeks certification. All professional certifications and coursework required by PMC will be paid through individual department budgets at the discretion of the department manager.

The following table summarizes employee eligibility and benefit amount:

Scheduled Hours Per Pay Period Annual Tuition Advance Funds

- 72 or more hours \$2,500 maximum/calendar year
- 48 - 71 hours \$2,000 maximum/calendar year
- 16 - 47 hours \$1,200 maximum/calendar year

Employee Discounts

All employees who are issued an ID badge are eligible for discounts from a wide range businesses.

DISCOUNTS INCLUDE

- **Automotive - tires, car rentals, maintenance**
- **Banking**
- **Electronics - cell phone, computers**
- **Entertainment**
- **Food and Lodging**
- **Physical Activity and Wellness**
- **Retail and Services**
- **Seasonal Discounts**

THE DISCOUNTS ARE SUBJECT TO CHANGE.

These links to products and vendors are being provided as a convenience and for informational purposes only.

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

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

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

SUMMARIES OF THE DISCOUNT PROGRAMS ARE AVAILABLE VIA THE [INTRANET](#)

Affordable Care Act

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

THE ACA IS INTENDED TO:

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

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

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

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

UVM HEALTH NETWORK'S ACTION UNDER ACA

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

THERE ARE THREE METHODS FOR DETERMINING ELIGIBILITY UNDER THE ACA:

• Method 1 - Hire

Employee is hired into a position that is expected to average 30 or more hours per week based on the weekly authorized hours entered into Workday, the employee is determined to be ACA-Eligible for coverage.

• Method 2 - Hire with Look Back:

Employee is hired into a position that is expected to average 30 or more hours per week based on the weekly authorized hours entered into Workday, the employee is determined to be ACA-Eligible for coverage.

- If an employee is eligible for insurance and reduces their hours at some point in the year, they are able to maintain their coverage for the remainder of the year assuming they continue employment and had an average of 30 hours per week prior to the reduction.

• Method 3 - Annual Look Back:

An annual "look back" is performed for employees who are not eligible for the standard medical insurance plans, by looking at their worked hours for UVMHN over the past year (from November through October). The annual "look back" is to determine if the employee averaged 30 or more hours per week based on the actual time worked. If the hours average 30 or more per week, the employee is ACA-Eligible for coverage beginning January 1 of the following year.

2019		2020						2021					
Nov	Jan	Mar	May	Jul	Sep	Nov	Jan	Mar	May	Jul	Sep	Nov	
Measurement Period							Wait Period	Stability Period					
<ul style="list-style-type: none"> • Total number of hours worked: 1,596 • Average number of hours worked per month: 133 								<ul style="list-style-type: none"> • Employee is determined to be full-time • Employee must be offered benefits 					

ACA-ELIGIBLE EMPLOYEE MEDICAL COVERAGE AT UVMHN

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

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

ACA-ELIGIBLE OPEN ENROLLMENT

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

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

HOW TO ENROLL

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

ANNUAL TIMELINE FOR ACA ACTIONS

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

PAYING FOR COVERAGE

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

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

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

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

ACTION AFTER RECEIVING IRS FORM 1095(C)

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

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

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

COBRA Overview

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

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

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

LOSING COVERAGE UNDER UVMHN PLANS

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

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

ENROLLING IN COBRA BENEFITS

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

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

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

BENEFIT PROVIDED BY:
EBPA

CONTACT INFORMATION:

Phone
(888) 232-3203

PLANS AVAILABLE FOR CONTINUATION:

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

PREMIUMS:

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

Premiums are paid directly to the COBRA Administrator.

PAYING FOR COBRA THROUGH EBPA

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

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

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

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

Important Legal Notices for The University of Vermont Health Network

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

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

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

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

To request special enrollment or to obtain more information about the Plan’s special enrollment provisions, contact Benefits at (802) 847-2825, option 2 or Benefits@UVMHealth.org.

NOTICE OF PATIENT PROTECTIONS

The UVMHN Medical Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Cross Blue Shield of Vermont (BCBSVT) designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCBSVT at (800) 422-6668.

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

You do not need prior authorization from The University of Vermont Health Network Medical Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact BCBSVT at (800) 422-6668.

LIFETIME AND ANNUAL LIMITS

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

PREVENTIVE COVERAGE UPDATES

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. The deductibles and coinsurance are found in the Plan's summary plan description. Contact BCBSVT 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 1-800-422-6668, or visit www.bcbsvt.com.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

COVID-19 RELATED SERVICES

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

Appendix

2021 MEDICAL, DENTAL, & VISION BI-WEEKLY RATES

FULL-TIME

Plan	Bi-weekly Pre-tax Cost Share		Your Annual Cost	Annual Cost (You + Porter)
MEDICAL				
Premier 250	Your Cost (25%)	Porter (75%)		
1 Person	\$90.98	\$315.39	\$2,365.48	\$9,461.64
2 Person	\$182.00	\$630.95	\$4,732.00	\$18,928.44
Family	\$241.13	\$835.93	\$6,269.38	\$25,077.72
Premier 400	Your Cost (25%)	Porter (75%)		
1 Person	\$87.05	\$301.76	\$2,263.30	\$9,052.80
2 Person	\$174.14	\$603.69	\$4,527.64	\$18,110.64
Family	\$230.71	\$799.81	\$5,998.46	\$23,994.12
HDHP 1500	Your Cost (25%)	Porter (75%)		
1 Person	\$79.98	\$284.18	\$2,079.48	\$8,317.44
2 Person	\$159.99	\$568.52	\$4,159.74	\$16,639.44
Family	\$211.97	\$753.21	\$5,511.22	\$22,045.08
HDHP 3000	Your Cost (25%)	Porter (75%)		
1 Person	\$74.26	\$263.86	\$1,930.76	\$7,722.72
2 Person	\$148.55	\$527.87	\$3,862.30	\$15,449.64
Family	\$196.82	\$699.35	\$5,117.32	\$20,468.76
DENTAL				
Core	Your Cost	Porter		
1 Person	\$0.00	\$19.85	\$0.00	\$516.00
2 Person	\$16.15	\$19.85	\$419.90	\$936.00
Family	\$45.69	\$19.85	\$1,187.94	\$1,704.00
Buy-up	Your Cost	Porter		
1 Person	\$1.38	\$19.85	\$35.88	\$552.00
2 Person	\$18.92	\$19.85	\$491.92	\$1,008.00
Family	\$50.77	\$19.85	\$1,320.02	\$1,836.00
VISION				
Core	Your Cost (100%)	Porter (0%)		
1 Person	\$2.65	\$0.00	\$68.90	
2 Person	\$4.64	\$0.00	\$120.64	
Family	\$6.62	\$0.00	\$172.12	
Buy-up	Your Cost (100%)	Porter (0%)		
1 Person	\$4.20	\$0.00	\$109.20	
2 Person	\$7.36	\$0.00	\$191.36	
Family	\$10.50	\$0.00	\$273.00	

HSA CONTRIBUTION LIMITS

2021 HSA CONTRIBUTION LIMITS	UVMHN HDHP WITH HSA PLAN - 1500		UVMHN HDHP WITH HSA PLAN- 3000	
	Single	Family	Single	Family
UVMHN Contribution	\$500	\$1,000	\$1,000	\$2,000
Your Contribution	Up to \$3,100	Up to \$6,200	Up to \$2,600	Up to \$5,200
Total Contribution allowed by the IRS for anyone age 54 and under.	\$3,600	\$7,200	\$3,600	\$7,200
HSA Catch-up Contribution for anyone age 55+ by end of calendar year.	\$1,000	\$1,000	\$1,000	\$1,000

2021 EMPLOYER HSA CONTRIBUTIONS

2021 EMPLOYER HSA CONTRIBUTIONS		UVMHN HDHP WITH HSA PLAN - 1500		UVMHN HDHP WITH HSA PLAN- 3000	
Month Contribution will be made	Hire Date/Qualifying Date *	Single	Family	Single	Family
January	January - March	\$250	\$500	\$500	\$1,000
April	April - June	\$84	\$167	\$167	\$334
July	July - September	\$83	\$166	\$166	\$333
October	October - December 1	\$83	\$166	\$166	\$333

* Contributions will be made within 30 days of hire or qualifying event date.

LIFE INSURANCE

ADDITIONAL LIFE INSURANCE RATES		
Bi-weekly Rates are per \$1,000 of Coverage	Employee	Spouse
	Term Life with AD&D	Term Life
Age 29 and Under	\$0.0323	\$0.0438
30-34	\$0.0369	\$0.0485
35-39	\$0.0462	\$0.0577
40-44	\$0.0501	\$0.0623
45-49	\$0.0600	\$0.0715
50-54	\$0.0877	\$0.0992
55-59	\$0.1320	\$0.1435
60-64	\$0.2308	\$0.2423
65-69	\$0.3185	\$0.3300
70-74	\$0.5954	\$0.6069
Age 75 and Over	\$0.9600	\$0.9715
Child Term Life	\$0.0572	

CALCULATING LIFE INSURANCE PREMIUMS:

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

\$100,000 / \$1,000 = \$100 x \$0.060 = \$6.00

Bi-weekly premium for \$100,000 of coverage will be \$6.00 or \$156 annually

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

\$50,000 / \$1,000 = \$50 x \$0.0501 = \$2.505

Bi-weekly premium for \$50,000 of coverage will be \$2.505 or \$65.13 annually

IMPUTED INCOME ON EMPLOYER PAID LIFE INSURANCE

CALCULATING IMPUTED INCOME ON EMPLOYER PAID LIFE INSURANCE ABOVE \$50,000 To determine the amount of imputed income - use your age at the end of the calendar year and the rates noted to the right. You have \$64,000 in term coverage Imputed Income only applies to \$14,000 - the amount of coverage above \$50,000 Your age at the end of the calendar year - 47 (Rate from Chart: \$0.069) \$14,000 / \$1,000 = \$14 x \$0.069 = \$0.97 You would have \$0.97 of additional taxable income each pay period or \$25.22 annually. \$41.60 annually	BI-WEEKLY IMPUTED INCOME RATE PER \$1,000 OF BENEFIT	
		Age 24 and under
	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

VOLUNTARY 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 plus Spouse	\$9.94	\$258.48	\$19.51	\$507.36
Employee plus Child(ren)	\$7.73	\$200.88	\$15.16	\$394.20
Family	\$13.10	\$340.68	\$25.79	\$670.44

VOLUNTARY 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

VENDOR CONTACT INFORMATION

WHO DO I CALL FOR...	Company	Phone & Fax	Website, Email, Mobile App
General Inquiries, Making Changes to your Benefits	Benefits Department	(802) 847-2825, option 2	Email: Benefits@UVMHealth.org Mobile App: Workday Organization ID: uvmhealth
Payroll Direct Deposit Kronos	Payroll	(802) 338-4780, option 6	
Work/life balance Counseling/Referral Critical Incident Response Debrief	Employee & Family Assistance Program	(800) 964-3577	GuidanceResources.com
403(b) - Retirement Account	Fidelity Investments	(800) 343-0860	Website: netbenefits.com/UVMMedCenter Mobile App: NetBenefits
Medical Coverage (physical and behavioral)	Blue Cross Blue Shield of Vermont	(800) 422-6668	Website: bcbsvt.com Email: CustomerService@bcbsvt.com
Prescription Coverage	Navitus Health Solutions	(866) 333-2757	Website: navitus.com Mobile App: Navitus
Prescription Refills Specialty Pharmacy	UVM Health Network Pharmacy	(800) 284-6630 8:30am - 5pm; M-F	Email: SpecialtyPharmacy@UVMHealth.org Mobile App: UVM Health Rx
Dental Insurance	Northeast Delta Dental	(800) 832-5700	Website: deltadental.com Mobile App: Delta Dental Mobile
Vision Insurance	Vision Service Plan	(800) 877-7195	Website: vsp.com Mobile App: VSP Vision Care on the Go
Health Savings Account	HealthEquity	(866) 346-5800	Website: HealthEquity.com Mobile App: HealthEquity Mobile
Flexible Spending Account Limited Purpose FSA Dependent Care FSA	HealthEquity (formerly WageWorks)	(866) 346-5800	Website: WageWorks.com Mobile App: EZ Receipts
Short-term Disability Long-term Disability Family Medical Leave	The Hartford	(888) 716-4549	Website: TheHartfordatWork.com
Life Insurance	The Hartford	(888) 716-4549	Website: thehartford.com/employee-benefits/claims
Tuition Reimbursement Certification Reimbursement Program	Human Resources	338-4780, option 1	
Hospital Indemnity	Voya	(877) 236-7564	Website: Presents.voya.com/EBRC/UVMHNN
Pet Insurance	Nationwide Pet Insurance	Enrollments: (877) 738-7874 Policyholder Customer Care: (800)540-2016	Website: petsnationwide.com Email: SubmitMyClaim@petinsurance.com Mobile App: VitusVet
Identity Theft Protection	Allstate (formerly InfoArmor)	(800) 789-2720	Website: myaip.com/uvmhealthnetwork Mobile App: Allstate Identity Protection
Cobra Benefit Continuation	EBPA	(888) 232-3203	Website: ebpabenefits.com Email: cobra@ebpa.com

Common Health Insurance Terminology

AGGREGATE/NON-EMBEDDED VS. EMBEDDED DEDUCTIBLE

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

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

ALLOWED AMOUNT

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

BENEFIT YEAR

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

CARVE-OUT

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

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

COINSURANCE

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

COPAYMENT/CO-PAY

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

DEDUCTIBLE

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

ER, URGENT CARE, OR PCP?

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

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

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

EXCLUDED SERVICES

Any health care service that BCBSVT 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 BCBSVT sends in the mail after you receive a health service. It tells you how much the provider charged, how much BCBSVT will allow, how much your insurance paid, and the amount you may owe.

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

FORMULARY

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

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

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

FSA

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

HSA

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

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

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

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

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

MEDICALLY NECESSARY

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

MEDICARE

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

MEDICARE PART A (HOSPITAL INSURANCE)

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

MEDICARE PART B (MEDICAL INSURANCE)

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

MEDICARE PART C (MEDICARE ADVANTAGE PLANS)

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

MEDICARE PART D (PRESCRIPTION DRUG COVERAGE)

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

NETWORK

The facilities, providers, and medical suppliers BCBSVT 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, BCBSVT 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 BCBSVT 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 at 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).