

2023 Benefits Enrollment Guide

October 31, 2022 – November 11, 2022



**Health and Welfare
Benefits**

Open Enrollment

Welcome to your 2023 Benefits Enrollment Guide! We are excited to present our benefit plan offerings for 2023. We sincerely hope that you take time to learn as much as possible about what is available for you and your family.

Participation in Annual Open Enrollment is mandatory for all benefit-eligible employees, even if you do not intend to make any benefit changes for 2023.

- **If you want to keep the same benefits for 2023**, you must still complete the Declaration of Health Care form (page 4).
- **If you are making changes to your benefits for 2023**, you must complete the Declaration of Health Care form (page 4), the Open Enrollment Questionnaire (page 5) and the Benefit Plan Enrollment form. The Benefit Plan Enrollment form and Premium Rate Sheet will be distributed by your administration.

Annual Open Enrollment will take place October 31, 2022 through November 11, 2022. All benefit elections will become effective January 1, 2023 and remain in effect until December 31, 2023.

2023 Open Enrollment Meetings

There will be two benefit informational meetings:

Tuesday November 1st, 2022

3:30pm-4:30pm

The Roman Catholic Diocese

Degoesebriand Conference Room

55 Joy Drive, S. Burlington

Wednesday November 2nd, 2022

12:00pm-1:00pm

Virtual Meeting via Teams

Meeting ID: 242 639 375 332

Passcode: RMY994

For the meeting link, please contact HR at 802-658-6110 x1216
or email cbeaupre@vermonthcatholic.org

Open Enrollment

This benefits enrollment guide is your manual to the resources, key updates, changes and answers to your common questions about the health plans available to you. Reviewing the guide and its resources will inform your choices for this fall's Open Enrollment period.

MY OPEN ENROLLMENT CHECKLIST

- READ Benefits Enrollment Guide
- ATTEND one of the Open Enrollment Meetings
- COMPARE Plans
- REVIEW FAQs and other resources
- If you are not making any changes, COMPLETE, sign and return:
 - Declaration of Health Care form
- If you are making changes to your benefit selections, COMPLETE, sign and return:
 - Declaration of Health Care form
 - Open Enrollment Questionnaire
 - Benefit Plan Enrollment form

| | | |
|-------------------------|--|--|
| VT Form HC-2 | DECLARATION OF HEALTH CARE COVERAGE | This form must be completed annually by all uncovered employees. Employers must retain this form for 3 years. |
|-------------------------|--|--|

Employer: This form is **only** to be completed by employees if you offer to pay a portion of a health care plan that provides hospital and physicians services to at least some of your employees. You must retain all employee declaration forms together in a file for three years and be able to produce them in the event of an audit.

Name of location where you work *(Please print)* _____

Employee: Complete and sign this form and return it to your employer. The purpose of this form is to obtain information regarding your health care coverage. The information you provide on this form will be used solely for purposes of determining if your employer must pay Health Care Contributions as required under Vermont law at 32 V.S.A § 10503.

| | |
|---|----------------------|
| Employee's Full Name <i>(Please print)</i> | |
| Employee ID or Social Security Number | Date of Birth |

Will the employee be under the age of 18 for the entire calendar year? YES NO

If **YES**, stop. Please sign the bottom of the form and submit it to your employer.

If **NO**, please continue to complete this form and submit it to your employer.

Check the box beside the statement that best describes your health care coverage.

1. My employer offers health care coverage to me.

I have accepted the health care coverage offered and provided by my employer.

2. My employer offers health care coverage to me, and I have not accepted my employer's coverage.

I have health care coverage that includes hospital and physicians services from a source other than Medicaid or Vermont Health Benefit Exchange.

My coverage is provided through: _____

I am a full-time employee and have health care coverage as an individual through the Vermont Health Benefit Exchange.

I have Medicaid.

I have no health care coverage.

3. My employer does not offer health care coverage to me.

I am a part-time employee who works fewer than 30 hours per week, **and** I have coverage from a source other than Medicaid that offers hospital and physicians services.

I am a seasonal employee who expects to work for this employer 20 or fewer weeks during this calendar year, **and** I have coverage from a source other than Medicaid that offers hospital and physicians services.

I have health care coverage that offers hospital and physicians services.

My coverage is provided through: _____

I am a part-time or seasonal employee, and I do not have health care coverage **or** I am covered by Medicaid.

I have no health care coverage.

I certify the above information is accurate and true to best of my knowledge and belief.

Employee Signature _____ Date _____

Note: If your health care coverage changes within the year, you must complete a new Declaration of Health Care Coverage.



2023 Open Enrollment Questionnaire

Medical (please select at least one)

- I would like to keep the same plan next year
- I would like to switch plans next year. The plan I want beginning 1/1/23 is **Platinum - Gold - Silver** (circle one)
- I need to add or remove dependents on my policy (enrollment form required)
- I would like to drop my medical plan effective 12/31/22 (enrollment form required)
- I would like to enroll in a medical plan next year (enrollment form required)
- I'm not currently enrolled in medical and would like to decline medical again in 2023
- I work less than 30 hours a week and I am not eligible for benefits

Dental (please select at least one)

- I would like to keep the same plan next year
- I would like to switch plans next year. The plan I want beginning 1/1/23 is **High Option or Low Option**(circle one)
- I need to add or remove dependents on my policy (enrollment form required)
- I would like to drop my dental plan effective 12/31/22 (enrollment form required)
- I would like to enroll in a dental plan next year (enrollment form required)
- I'm not currently enrolled in dental and would like to decline dental again in 2023
- I work less than 30 hours a week and I am not eligible for benefits

Vision (please select at least one)

- I would like to keep the same plan next year
- I need to add or remove dependents on my policy (enrollment form required)
- I would like to drop my vision plan effective 12/31/22 (enrollment form required)
- I would like to enroll in a dental plan next year (enrollment form required)
- I'm not currently enrolled in vision and would like to decline vision again in 2023
- I work less than 30 hours a week and I am not eligible for benefits

Name: _____ Signature: _____

Date: _____

Benefit Basics

ELIGIBILITY

Employees are eligible to enroll in health and welfare benefits--medical, dental, and vision--during Open Enrollment if the employee works at least 30 hours per week and according to company policy. Seasonal and temporary employees are not eligible.

Dependents are your legally married spouse and/or any biological, adopted, foster or stepchildren, or any child for whom you are court appointed as legal guardian (up to age 26).

KEY TERMS TO KNOW

Deductibles are the amount you pay for covered health care services before your insurance plan starts to pay.

Copayments (copays) are the fixed dollar amounts (for example, \$15) you pay for covered health care, typically at the time of service.

Coinsurance is the percentage of costs of a covered health care service that you pay (20%, for example) after you've paid your deductible.

Generic drugs contain the same active ingredients as brand-name drugs, but generally are less expensive.

Preferred brand drugs are brand-name drugs that are listed on the plan's preferred list of prescription drugs.

Non-preferred brand drugs are brand-name drugs that are not included on the plan's preferred list of prescription drugs. These may not be covered under the plan.

Specialty drugs are used to treat certain complex health problems. These drugs tend to be very expensive.

An **Exclusive Provider Organization (EPO)** plan provides coverage to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs.

WHEN CAN I MAKE CHANGES TO BENEFITS?

Generally, changes are only allowed under the following circumstances.

Annual Open Enrollment Period

Once a year we conduct an Annual Open Enrollment (usually in the fall). During this time, you can add or drop benefit plans, and add or remove dependents from your coverage for the coming plan year.


Qualifying Life Events (QLEs) / Change in Family Status

Outside of Annual Open Enrollment, you may change your benefit elections during the year only if you experience a Qualifying Life Event. Below are examples of life events that may allow you to make a change.



Medical | MVP Health Care

The premiums listed at the bottom of the page are total monthly premiums for MVP PLATINUM, GOLD and SILVER plans. Your employer contributes toward each employee's monthly premium based on: employer/location, the number of regular scheduled hours worked each week, and the type of coverage. You will pay a share of this premium, per pay period. The administration office at your location will distribute a Benefit Rate Sheet. The Benefit Rate Sheet will show your cost per pay period. If you do not receive one, please see your administration office for a copy.

|  | Standard PLATINUM | Standard GOLD | Standard SILVER |
|--|--|--|--|
| Preventive Care | Covered 100% | Covered 100% | Covered 100% |
| Telemedicine Services <i>myVisitNow® & myERnow®</i> | \$0 for all emergency, urgent and primary care, as well as nutrition, mental health and psychiatry | | |
| Physician Services Primary Care Office Visit * Chiropractic & PT Office Visit Specialist Office Visit Urgent Care Emergency Room | \$15 Copay \$20 Copay \$40 Copay \$50 Copay Deductible, then \$100 | \$20 Copay \$30 Copay \$50 Copay \$60 Copay Deductible, then \$150 | \$40 Copay \$50 Copay \$90 Copay \$100 Copay Deductible, then \$500 |
| Physician Services Primary Care Office Visit * | <i>3 office visits per member at no cost share, then:</i> \$15 | <i>3 office visits per member at no cost share, then:</i> \$20 | <i>3 office visits per member at no cost share, then:</i> \$40 |
| Medical Deductible Individual/Family | \$425/ \$850 | \$1,400/ \$2,800 | \$4,000/ \$8,000 |
| Rx Deductible Individual/Family | N/A | \$200/ \$400 | \$500/ \$1,000 |
| Medical Out-of-pocket Max Individual/Family | \$1,500/ \$3,000 | \$5,600/ \$11,200 | \$9,100/ \$18,200 |
| Rx Out-of-pocket Max Individual/Family | \$1,400/ \$2,800 | \$1,400/ \$2,800 | \$1,400/ \$2,800 |
| Hospital Services Inpatient/Outpatient Imaging (CT/PET/MRI) Lab & X-Ray | Deductible, then plan pays 90% | Deductible, then plan pays 70% | Deductible, then plan pays 50% |
| Prescriptions Retail 30-day Supply | Generic: \$10 Preferred Brand: \$50 Non-Preferred Brand: 50% | Generic: \$12 Preferred Brand: Deductible, then \$55 Non-Preferred Brand: Deductible, then 50% | Generic: \$20 Preferred Brand: Deductible, then \$70 Non-Preferred Brand: Deductible, then 50% |
| Total MONTHLY Premium | | | |
| Employee | \$970.41 | \$801.64 | \$669.71 |
| Employee + Spouse | \$1,940.82 | \$1,603.28 | \$1,339.42 |
| Employee + Child(ren) | \$1,872.89 | \$1,547.17 | \$1,292.54 |
| Family | \$2,726.85 | \$2,252.61 | \$1,881.89 |


The text contained in this Guide was taken from various summary plan descriptions and benefit information. In the case of a discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. If you have any questions about your Guide, contact Human Resources.

Dental | Northeast Delta Dental

We offer two dental plans through Northeast Delta Dental. You'll see from the chart below, there are differences in coverage, so it's important you choose the plan that is right for your needs. Look at the factors such as the amount you pay for coverage, annual deductible, annual maximum, and your out-of-pocket costs on services.

SAVE MONEY IN THE NETWORK. Although Northeast Delta Dental allows you to visit any provider you would like, staying in the Delta Dental network will provide you with the highest level of benefits. Non-network providers can balance bill you for any amount above what Northeast Delta Dental considers "Usual and Customary." Visit nedelta.com to see who is in the network.

Employees pay the full cost for this coverage and pay period deductions are shown in your Benefits Rate Sheet. Premiums will be deducted bi-weekly or semi-monthly from your paycheck on a pre-tax basis.


|  DELTA DENTAL | HIGH OPTION | LOW OPTION |
|--|-------------------------------|-------------------------------|
| Office Visit Copay | \$20 | \$20 |
| Diagnostic/Preventive (Coverage A) No waiting period | You pay 0% | You pay 0% |
| Basic Services (Coverage B) No waiting period | You Pay 20% | You Pay 30% |
| Major Services (Coverage C) 6-month waiting period | You pay 50% | You pay 50% |
| Orthodontia Services (Coverage D) 6-month waiting period | You pay 50% | You pay 50% |
| One-time Deductible Individual/Family (Coverages B & C Only) | \$100/\$300 | \$75/\$225 |
| Calendar Year Maximum (Coverages A, B, C) | \$2,000 | \$1,500 |
| Lifetime Orthodontics Maximum (Coverage D) | \$1,500 | \$1,250 |
| Carryover Benefit | \$250 per year \$4,000 max | \$250 per year \$3,000 max |
| Total MONTHLY Premium | | |
| <i>Employee</i> | \$41.64 | \$36.18 |
| <i>Employee + 1</i> | \$76.36 | \$66.30 |
| <i>Family</i> | \$134.10 | \$116.14 |

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Vision | VSP

Vision coverage is available to all eligible employees through Vision Service Provider (VSP). Remember, you'll save on eyewear and eye care when you visit a VSP network doctor. To learn what doctors are in your network, call 800.877.7195 or visit vsp.com.

Employees pay the full cost for this coverage. Refer to your Benefits Rate Sheet for your pay period deduction amount. Premiums will be deducted bi-weekly or semi-monthly from your paycheck on a pre-tax basis.

| BENEFIT | DESCRIPTION | COPAY | FREQUENCY |
|--|--|-------------------------------------|---|
| Well Vision Exam | Focuses on your eyes and overall wellness | \$20 | Every calendar year |
| Prescription Glasses | | \$20 | See below for frame and lenses |
| Frame | \$180 allowance for a wide selection of frames 20% savings on the amount over your allowance \$80 Walmart frame allowance | Included in Prescription Glasses | Every <u>other</u> calendar year |
| Lenses | Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children | Included in Prescription Glasses | Every calendar year |
| Lens Enhancements | Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 35-40% on other lens enhancements | \$0 \$80 - \$90 \$120 - \$160 | Every calendar year |
| Contacts | \$130 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) | Up to \$60 | Every calendar year |
| Get the most out of your benefits and greater savings with a VSP network doctor. | | | |
| Total MONTHLY Premium | | | |
| | Employee | \$9.40 |  |
| | Employee + Spouse | \$13.63 | |
| | Employee + Family | \$24.43 | |

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Frequently Asked Questions

Q: I'm not planning on making any changes to my benefits, do I need to do anything?

A: Yes, all employees are required to complete the Declaration of Health Care Coverage form.

Q: I need to make a change to one or more of my benefits. What forms do I need to complete?

A: You will need to complete the Declaration of Health Care form, the Open Enrollment Questionnaire and the Benefit Plan Enrollment form.

Q: Why are the premium/paycheck deductions increasing for the medical plans?

A: Managing healthcare costs is a continuing challenge. National health care spending costs continue to climb and, according to recent reports, are expected to grow an estimate of 5.8% annually through 2024. Contributing factors for cost increases are driven mainly by rising medical and pharmaceutical costs, particularly specialty drug costs.



Q: What are some things I can do to help me save on health care costs?

A: Some actions you can take to help reduce costs are:

Preventive Care

To stay on the healthy track, be sure to take advantage of preventive care, such as annual exams. Preventive care is free under all the plans as long as you stay in network.

Choose Generic vs. Brand Name Prescriptions

Save money on prescriptions by requesting generic or lower-cost versions of the medicine you need (approved by your doctor), and take advantage of mail-order programs.

Using Urgent Care Facilities and limit Emergency Room Visits

Don't run to the emergency room for needs that are better suited to a doctor's office or an urgent care clinic.

Participate in MVP Health Care Wellness

Enrolled employees have access to a wide variety of online tools, activities, and education designed to support their health and wellness. From free wellness classes to exclusive discounts on wellness products and services, MVP is available to help you succeed at reaching your health improvement goal.

Annual Notices & Disclosures

COBRA Information:

COBRA continuation coverage is a temporary extension of coverage under the group health plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Benefits Coordinator in Human Resources.

Health Insurance Marketplace:

You may have other options available to you when you lose group health coverage. You may be eligible to buy an individual plan through the Health Insurance Marketplace (www.healthcare.gov). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

HIPAA Information:

Special Enrollment Right Mandated by the Health Insurance Portability and Accountability Act of 1996

Group health plans and health insurance insurers are required to provide special enrollment periods during which individuals who previously declined coverage for themselves and their dependents may be allowed to enroll without having to wait for the plan's next open enrollment period. A special enrollment period can occur if a person with other health coverage loses that coverage or if a person becomes a new dependent through marriage, birth, adoption or placement for adoption. If you refuse enrollment for yourself or your dependents for medical coverage, you may later enroll within 30 days of a change in family status or loss of health coverage.

Individuals may not be denied eligibility or continued eligibility to enroll for benefits under the terms of the plan based on specified health factors. In addition, an individual may not be charged more for coverage than similarly situated individuals based on these specific health factors.

Effective April 1, 2009, the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) created a new 60-day special enrollment period for eligible Team Members and dependents to immediately enroll in the plan if they become ineligible for Medicaid or any state's Children's Health Insurance Program (CHIP) and lose coverage or become eligible for that state's premium assistance program. The Team Member must request coverage within 60 days after the termination of coverage or the determination of subsidy eligibility.

Women's Health and Cancer Rights Act of 1998 (WHCRA):

WHCRA requires a group health plan to notify you, as a participant or a beneficiary, of your potential rights related to coverage in connection with a mastectomy. Your plan may provide medical and surgical benefits in connection with a mastectomy and reconstructive surgery. If it does, coverage will be provided in a manner determined in consultation with your attending physician and the patient for a) all stages of reconstruction on the breast on which the mastectomy was performed; b) surgery and reconstruction of the other breast to produce a symmetrical appearance; c) prostheses; and d) treatment of physical complications of the mastectomy, including lymphedema. The coverage, if available under your group health plan, is subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the plan. For specific information, please refer to your summary plan description or benefits booklet, or contact Human Resources.

Contact Information

Please refer to the list below when contacting one of the benefit vendors. For general information contact Human Resources.

| PLAN | VENDOR | CONTACT |
|---|---|--|
| Open Enrollment and General Benefits Inquiries | Mary Foster, Chief Human Resources Officer | mfoster@vermontcatholic.org 802-846-5846 |
| | Derek Pitts, Human Resources Specialist | dpitts@vermontcatholic.org 802-846-5841 |
| Medical Coverage | MVP Health Care | www.mvphealthcare.com 888-687-6277 |
| Dental Coverage | Northeast Delta Dental | www.nedelta.com 800-832-5700 |
| Vision Coverage | VSP | www.vsp.com 800-877-7195 |

Notes
