Green Mountain
Higher Education Consortium
Champlain • Middlebury • Saint Michael's

2024 Employee Benefits Guide

January 1, 2024 to December 31, 2024

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Welcome to Your Employee Benefits Guide

At Green Mountain Higher Education Consortium, we are committed to a comprehensive employee benefits program that helps our employees stay healthy, feel secure, and maintain a work/life balance. It is our pleasure to provide you with a copy of the 2024 Employee Benefits Guide.

This booklet is designed to provide you with information to make enrollment decisions that best meet your needs. The booklet highlights key features of the benefits program and will answer many of your immediate questions.

The guide will acquaint you with the benefits and health care plans available to employees and eligible family members of Green Mountain Higher Education Consortium.

We hope that you find this guide useful as you weigh your benefit options.

We encourage you to take time to educate yourself about your options and choose the coverage that best fits the needs of you and your family.

Eligibility, Enrollment and Mid-Year Changes

Eligibility

- If you are a full-time employee, working 30 or more hours per week, you are eligible to enroll in the benefits described in this guide. Your spouse & dependent children are eligible to enroll in the medical, dental, and vision plans.
- If you are a part-time employee working 20 or more hours per week, you are eligible to enroll in the 403(b) Retirement plan.
- All employees, regardless of number of hours worked, are eligible to participate in the Employee Assistance Program.
- Benefits start on the 1st of the month following date of hire. If your date of hire is on the 1st of the month your benefits are effective that day.

Enrollment

During annual open enrollment, all employees must complete online enrollment in Oracle between November 27th to December 4th, 2023. All enrollment changes will be effective January 1, 2024.

Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualifying life event.

New employees will have 30 days from their date of hire to enroll in benefits.

Mid-Year Changes

Health, dental and vision benefits are paid for on a pre-tax basis and federal law limits your ability to make changes to these coverages outside open enrollment unless you experience a qualifying life event. Examples include marriage, divorce, legal separation, birth or adoption of a child, death of a dependent, and change in spouse's employment status.

If you experience a qualifying life event you must notify The Benefits Team within 30 days of the date the event occurring in order to make a change to your current elections.

Disclaimer:

The information in this Benefits Guide is designed to provide an overview of the benefits offered through Green Mountain Higher Education Consortium. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible.

Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These official documents govern your benefits program.

If there is any discrepancy between the Benefits Guide and the official documents, the official documents prevail. These documents are available upon request through The Benefits Team. Information provided in this brochure is not a guarantee of benefits. Green Mountain Higher Education Consortium reserves the right to modify, change, revise, amend or terminate these benefits plans at any time. If you have any questions about this summary, email peopleservices@gmhec.org.

2024 Open Enrollment

November 27, 2023 to December 4, 2023

Plan year is from to January 1, 2024 to December 31, 2024.

Please log into Oracle no later than December 4, 2023 to make your 2024 benefit elections even if you don't plan on making changes.

Steps to Enroll in Oracle

The plans you enroll in will be effective from 1/1/24 (or your benefits eligibility effective date) through 12/31/24.

LOGIN TO ORACLE

1. To get started with self-service enrollment, you will need to navigate to **Oracle**. Click Oracle.
2. From the **Me** tab, click **Benefits**.
3. Click **Make Changes**, or **Start Enrollment** (if you are new to benefits), under your name in the middle of the screen.

BEFORE YOU ENROLL, UPDATE BENEFICIARIES AND DEPENDENTS

Collect your dependents' information if you intend to add them to your plans or name them as beneficiaries. You'll need full names and dates of birth.

1. Click **Add** to add each individual you intend to add as a dependent on your insurance plans and/or name as a beneficiary on your life insurance.
   - Enter required information.
   - Important: In the ***What's the start date of this relationship?*** box, enter a birthday or anniversary date prior to your benefits effective date.
   - To not enroll a contact, do not select them when you enroll in a benefit.
   - Click **Submit**.
2. Once all of your people have been added, click **Continue**.

ELECTING BENEFITS

Be sure to select your beneficiaries for all Life & AD&D plans.

1. Click on your **Health & Welfare Program** icon.
2. Read and **Accept** the Authorization.
3. Click the **Edit** button next to each group of benefits to enroll in.
   - Click the check box next to each benefit you would like to enroll in.
   - Click the check box next to each dependent you would like to enroll.
   - If you are editing who is enrolled in a plan, click the **pencil** next to the plan to modify your enrollment.
   - Click **OK** then **Continue**.
4. Follow the steps in 3 above for each benefit you wish to enroll in or make changes to.
   - If enrolling in a Flexible Spending (medical or dependent care) or Health Savings Account, you will need to include annual contribution amounts. The IRS requires you to enroll in these each year.
   - Once you have selected all benefits you would like to enroll in, scroll to the top and click **Submit**. Right click in the Confirmation Page and choose to print a paper copy or save as a pdf.

     If you view a confirmation page, you have successfully completed your enrollment. If you do not see a confirmation page, ensure you have clicked the Submit button.

REVIEW AND RESOLVE ACTION ITEMS

1. Navigate back to the **Benefits** page.
2. Click **Pending Actions.**
3. Review any actions requiring resolution.
   - Click the item, make necessary changes, and click on Submit.
   - If you have enrolled in Life Insurance requiring an Evidence of Insurability form, the benefits team will reach out to you with a link to the form and resolve this Pending Action for you once requirements have been met.

ENROLL IN RETIREMENT PLAN

1. Click on your Retirement Program icon.
2. Click **Continue** on the Before You Enroll page.
3. Click the **Edit** button. Select the plan(s) you would like to contribute to. Enter the percentage of your pay you would like to contribute.
4. Click **OK**.
5. Click **Continue**.
6. Click **Submit**.

Medical Benefits

Provided by: **MVP**
Phone: 888.687.6277
Website: https://www.mvphealthcare.com/
Policy #: 431316

Benefits You Receive:

The medical plans provide coverage for physician office visits, hospitalization, emergency care, and more. Coverage for prescription drugs is also included. The plans offer an extensive network of providers that have met the credentialing standards of MVP and allow the flexibility of choosing from In-Network and Out-of-network providers. By utilizing In-Network providers, you have the added advantage of network-negotiated pricing which can save you money.

As a member of our MVP medical plan, you have the following resources available:

24/7 Nurse Advice Line at 1-800-204-4712

If you do not need care, but need advice, you have access to MVP's 24/7 Nurse Advice Line. Nurses are available to assist you in finding information and resources about prevention, wellness, treatments, chronic conditions and other health topics

Gia ® - available by mobile app , web or phone 24/7

Gia can connect you to MVP's free virtual care services, in-person care from nearby doctors, specialists, labs, pharmacies and more.

You can visit **GoAskGia.com** or call **1-877-GoAskGia** (1-877-462-7544).

Plan Highlights include:

1. Network Strength
2. 24/7 Acess to Quality Care, Plan Information & Cost Savings
3. $600 Well-Being Reimbursement
4. $500 Acupuncture Allowance
5. New in 2024, annual hearing aid exam and equipment covered under durable medical equipment benefit and subject to deductible and out-of-pocket maximum.

Visit mvphealthcare.com/newthisyear or contact your MVP Account Representative to learn more. You can also find more information on Gia on the following page.

Find a Doctor or Facility Online
Visit **www.mvphealthcare.com/findadoctor** to watch an online video with step-by-step instructions.

Living Well Programs

MVP offers a variety of in-person and virtual classes and workshops to help you live well. Classes include but are not limited to mediation, tai chi and tobacco cessation. Visit www.mvphealthcare.com/LWCalendar for more information.

Summary of Benefits and Coverage (SBC)

As required by The Patient Protection and Affordable Care Act, Green Mountain Higher Education Consortium is required to provide each employee a summary of benefits and coverage (SBC) in a standardized format. The SBC is on the gmhec.org internal Employee Page. The information provided in the Benefits Overview is presented for illustrative purposes. For more detailed information, please refer to your summary plan description. In the case of a discrepancy, the actual plan documents will prevail.

MVP Non-Standard Gold HDHP

PLAN BENEFITS	HDHP OAP with HSA
	In-Network
Complimentary Account	HSA
Calendar Year Deductible	
Individual	$3,000
Family	$6,000
Out of Pocket Maximum (includes deductible)	
Individual	$3,000
Family	$6,000
Preventive Care Services	0% no deductible
Primary Physician	0% after deductible
Emergency Services (must be true emergency)	0% after deductible
Hospital-Inpatient Stay	0% after deductible
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan, Itrasound	0% after deductible
Prescription Drugs Retail (up to 30-day supply)	
Generic	0% after deductible
Preferred Brand Name	0% after deductible
Non-Preferred Brand	0% after deductible
Specialty Drugs	0% after deductible
Mail Order (up to 90-day supply)	
Generic	0% after deductible
Preferred Brand Name	0% after deductible
Non-Pref Brand Name	0% after deductible
Rx Out-of Pocket Maximum	$1,600 Individual $3,200 Family

*If you enroll in GMHEC's medical plan, we will contribute $1,600 for employee-only coverage and $3,200 for 2-person / family coverage. This amount will be divided over 26 pay periods. Employees may contribute the difference, up to the annual HSA contribution limit, throught payroll deductions.

Employer HSA Contributions		
	Annual	**Bi – Weekly**
Employee Only	$1,600	$61.54
2 – Person / Family	$3,200	$123.08

Vision Benefits

Provided by: **VSP**
Phone: 800.877.7195
Website: https://www.vsp.com
Policy #: 30082365

Vision coverage through VSP includes a wide range of services including exams, lenses, and prescription glasses. This plan offers an affordable eye care plan to help you see well and stay healthy. Discounts are also available for other eye care services.

Employees electing medical coverage will be automatically enrolled in the vision plan. Employees waiving coverage in GMHEC's medical plan may enroll in the vision plan. VSP does not issue ID cards. In-network VSP providers will only need your name to locate you, or a family member, in their system.

Vision

TYPE OF EXPENSE	Signature Plan B	Frequency
Exam	$0 copay	12 Months
Prescription Glasses **Standard Lenses: Single, Bifocal, Trifocal and Lenticular**	$0 copay	12 Months
Frames	• Covered up to $130 for a wide selection of frames • $150 allowance for featured frame brands 20% discount on amount over your allowance	Every 24 Months
Contact Lens (elective)	Covered up to $130	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses Average savings of 35 – 40% on other lens enhancements	12 Months
Extra Savings	Glasses and Sunglasses • Extra $20 to spend on featured frame brands. • 30% savings on additional glasses and sunglasses, incuding lens enhancements, from the same VSP providor on same day as Exam. Retinal Screening • No more than a $39 copay on routine retinal screening Laser Vision Correction • Average 15% off the regular price of 5% off promotional price; available from contracted facilities	

Dental Benefits

Provided by: **Northeast Delta Dental**
Phone: 800-832-5700
Website: https://www.nedelta.com/Home
Policy #: 70738-1000

The dental plan through Northeast Delta Dental allows you to receive care from any dentist; however, utilizing a contracted provider helps you reduce your out-of-pocket costs. Should you choose an out-of-network dentist, you will be responsible for the difference in what the out-of-network dentist charges for procedures and the contracted rate with network dentists.

Dental

	PPO + Premier
Calendar Year Maximum Benefit (per person)	$2,000 per person
One Time Deductible	$100 individual / $300 family
Preventive Services: Cleanings twice in a 12-month period, Oral Exams,Sealants, X-rays	0% no deductible
Basic Services: Fillings, Periodontal Maintenance	20% after deductible
Major Services: Crowns, Bridges, Dentures, Inlays, Onlays, Root Canal	50% after deductible*
Orthodontia: **Lifetime Maximum** **Benefit**	Adults & Children* $1,500 50%

*6-month waiting period applies

2024 Medical / Vision Rates^				
	TOTAL Monthly Premium Medical / Vision	**Employer Bi-Weekly Medical/Vision**	**Employee Bi-Weekly Medical/Vision**	**Employer Bi-Weekly HSA Contribution**
Single	$961.72	$365.88	$77.88	$61.54
Employee + Spouse	$1,917.88	$683.34	$201.84	$123.08
Employee + Children	$1,851.99	$667.35	$187.42	$123.08
Family	$2,699.97	$940.05	$306.09	$123.08

^Employees enrolling in medical plan are automatically enrolled in vision plan.

2024 Vision Rates^^			
	TOTAL Monthly Premium Vision	**Employer Bi-Weekly Vision**	**Employee Bi-Weekly Vision**
Single	$13.90	$5.13	$1.28
Employee + Spouse	$22.24	$7.60	$2.67
Employee + Children	$22.70	$7.86	$2.62
Family	$36.60	$12.16	$4.73

^^ Employees opting out of medical plan may enroll in vision only coverage

2024 Dental Rates			
	TOTAL Monthly Premium Dental	**Employer Bi-Weekly Dental**	**Employee Bi-Weekly Dental**
Single	$50.52	$18.65	$4.66
2 Person	$92.60	$32.05	$10.68
Family	$163.06	$52.68	$22.58

Group Life Insurance

Provided by: **Unum/Provident**
Phone: 800.887.2180
Website: https://services.unum.com
Policy #: 0751272

Group Life Insurance

GMHEC provides eligible employees with Group Term Life and Accidental Death and Dismemberment (AD&D) insurance equal to one-and-a-half (1.5) times your annual salary up to $200,000, with evidence of insurability being required for benefit amounts over $140,000. Coverage is automatic and requires no election by the employee, though beneficiary designation is required.

The policy offers an Accelerated Death Benefit, waiver of premium for disability, and continuation options in the event your employment ends. The AD&D plan pays a benefit in the event of death as a result of an accident. The policy also offers benefits in the event of dismemberment or paralysis as a result of an accident or injury.

Under current tax law, the value of group life insurance coverage over $50,000 is taxable income, called *imputed income*. Because GMHEC pays for the cost of group life insurance, you are responsible for paying taxes on the value of the coverage in excess of $50,000. The value is determined from tables published by the IRS. Imputed income will be reflected on your paychecks and on your W-2 form.

The Group Term Life Insurance plan pays the following benefit in the event of your death:

PROVIDED FOR	Coverage Amount*
Employee Only	1.5x annual salary to $200,000

*If you have reached age 70, but not age 75, your amount of life insurance will be: 65% of the amount of life insurance you had prior to age 70.

Designating a Beneficiary:

You must name the person(s) or entity to receive benefits in the event of your death. Please log into Oracle to update your beneficiary information. You are able to update your life insurance beneficiary at any time throughout the year, and as many times as needed.

Disability Insurance

Disability insurance is designed to ensure you receive a portion of your income while you are out of work, so that you can focus on recovery.

Our company provides **full-time employees with Short-Term and Long-Term Disability income benefits** and pays the full cost of this coverage. In the event that you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income.

	Short-term Disability	Long-term Disability
Benefit Amount	60% of your weekly earnings to a maximum benefit of $1,500 per week	60% of monthly earnings to a maximum benefit of $7,000 per month
When Do Benefits Begin?	Accident – 8 days Sickness – 8 days	91 days
How Long Are Benefits Paid?	12 weeks	Up to 5 years

Flexible Spending Account

Provided by: **Navia Solutions**
Phone: 1-800-669-3539
Website: https://app.naviabenefits.com/app/#/login

Flexible Spending Account

A Flexible Spending Account or FSA, also known as a flexible spending arrangement, is one of a number of tax-advantaged financial accounts. Money deducted from an employee's pay into an FSA is not subject to payroll taxes. However, FSA funds that are not used by the end of the year or grace period will be forfeited.

If you are enrolled in an HSA, then you still can enroll in the Limited-Purpose FSA (LPFSA). This LPFSA allows you to set money aside in an FSA, but it is limited to expenses for dental and vision only.

Benefits You Receive:

FSAs provide you with an important tax advantage that can help you pay eligible health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the upcoming year, you can actually lower your taxable income.

What is an eligible expense?

For a Health Care FSA, deductibles, coinsurance amounts, co-pays, and other expenses that are described in IRS Publication 502 - Medical and Dental Expenses, are considered eligible or qualified expenses. Premiums for health and other insurance aren't eligible expenses. You can use an FSA to pay for copayments, deductibles, some drugs, and some other health care costs, prescription medications, as well as over-the-counter medicines with a doctor's prescription.

For a Dependent Care FSA, expenses must be incurred for the care of eligible members of your family. See the complete list in IRS Publication 503—Child and Dependent Care Expenses. All expenses must take place within the benefit plan year.

FSAs may also be used to cover costs of medical equipment like crutches, supplies like bandages, and diagnostic devices like blood sugar test kits.

Rollover

Up to $610 of unused funds will go into your next plan year's account.

Dependent Care FSA

A dependent care FSA (DCFSA) is a pre-tax benefit account used to pay for eligible dependent care services, such as preschool, summer day camp, before or after school programs, and child or adult daycare.

ACCOUNT	2024 CONTRIBUTION LIMITS
Flexible Spending Account	$3,200
Limited-Purpose Flexible Spending Account	$3,200
Dependent Care Account	$5,000 per household

Health Savings Account

Provided by: **Health Equity**
Phone: (866) 346-5800
Website: www.healthequity.com
Policy #: 77015704

Health Savings Account

A Health Savings Account or HSA is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high deductible health plan - HDHP.

Funds contributed to an account are not subject to federal income tax at the time of deposit. Unlike a flexible spending account (FSA), funds roll over and accumulate year to year, if not spent.

HSA funds may currently be used to pay for qualified medical expenses at any time without federal tax liability or penalty.

If you exceed the annual limit, the IRS imposes a tax penalty on excess contributions. Additionally, you will be required to pay tax on the interest earned on those excess funds. **You are responsible for tracking your contributions to ensure you do not exceed the maximum allowable contribution.**

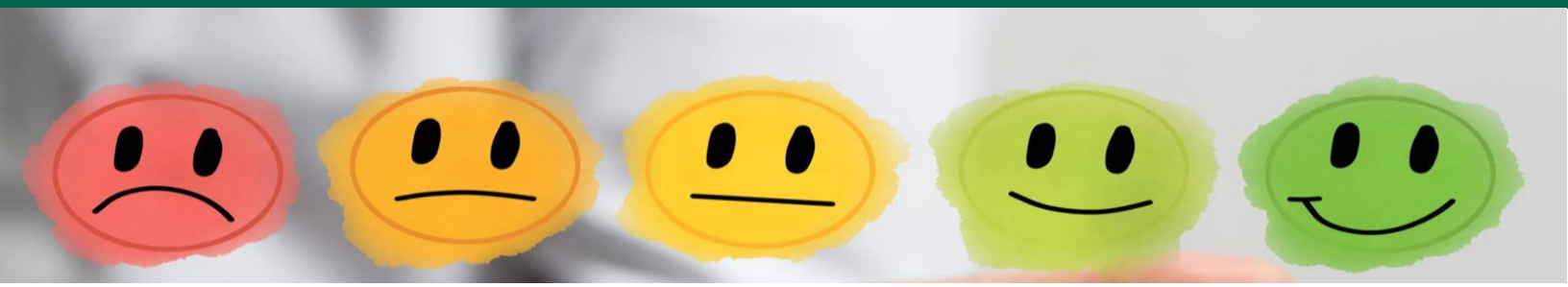
Limits for 2024	Employee	2-person / Family
GMHEC Contribution	$1,600	$3,200
HSA Contribution Limit	$4,150	$8,300
HSA Catch-up Contribution (Age 55 or older)	$1,000	$1,000

Manage your account online

At myhealthequity.com, you can:

- Check your account balances
- Make payments to providers
- Set up monthly payments to providers
- Transfer funds to your personal checking account
- Use the HSA Tool Kit as an additional resource

Employee Assistance Program



Provided by: **InvestEAP**
Phone: 1-866-660-9533
Website: https://www.investeap.org/
Password: gmhec

Employee Assistance Program (EAP)

An Employee Assistance Program (EAP) is a voluntary, work-based program that offers free and confidential assessments, short-term counseling, referrals, and follow-up services to employees who have personal and/or work-related problems. EAPs address a broad and complex body of issues affecting mental and emotional well-being, such as alcohol and other substance abuse, stress, grief, family problems, and psychological disorders. EAP counselors also work in a consultative role with managers and supervisors to address employee and organizational challenges and needs. Many EAPs are active in helping organizations prevent and cope with workplace violence, trauma, and other emergency response situations.

All employees working for GMHEC are eligible 1st of the month following date of hire.

If it's on your mind, give us a call!

- Counseling
- Resources
- Referrals
- Manager Consultations
- Financial advice and legal consultations
- Facilitate Discussions
- ….And support for anything else that's on your mind!

2024 GMHEC Employee Well-Being Resource Guide

What is well-being?

Well-being is “the combination and interaction between our love of what we do each day, the vibrancy of our physical health, the security of our finances, the quality of our relationships and the pride we take in what we have contributed to our communities” (Rath & Harter, 2010). High levels of well-being are what enable each of us to flourish and bring our best selves to life and work every day. At GMHEC, the well-being of our employees is a top priority and is what enables the Consortium to fulfill its mission to serve our customers with energy, enthusiasm and creativity.

Investing in our employees

To support our employees, the Green Mountain Higher Education Consortium offers a wide range of resources to support all five domains of well-being: career, physical, financial, social and community. On the following pages you will find a list of these resources. We encourage you to take advantage of all that we have to offer and thank you for all you do to support our member colleges, your coworkers and the community at large.

Get moving and get support to make healthy choices

- Daily well-being programming and events are posted on the calendar.

Calendar password is GMHECWell-Being. To sign up for the “What’s on Tap” newsletter and stay in the know about upcoming events, contact rebecca.schubert@gmhec.org.

- Discounted individual and family membership to The Edge
- MVP Well-being Rewards: Earn up to $600 annually
- MVP Telemedicine “My Visit Now”
- MVP Care Management and 24 hour nurse advice line
- Free, online yoga classes offered through Upper Valley Yoga. Contact rebecca.schubert@gmhec.org to set up your account.
- Free, local tobacco cessation support offered through the Vermont Department of Health

Take advantage of your benefits

Comprehensive benefits package including medical dental, disability, retirement, lifeinsurance, HSA and FSA

Tax deferred investment plan for all employees who are scheduled to work 20 hours per week or more including 403b consulting

Employee Family Assistance Program passcode is gmhec

Stay Connected

- Support groups to manage chronic conditions and other health and social challenges
- Eldercare support, referral and respite available through AgeWell
- Volunteer opportunities available through United Way of Northwest Vermont
- Addison Community Action offers fuel assistance, free tax preparation, matched savings program, Growing money program, financial futures program, and weatherization services for income qualified individuals
- Addison County HOPE improve the lives of low income people in Addison County, Vermont by working with individuals to identify and secure the resources needed to meet their basic needs

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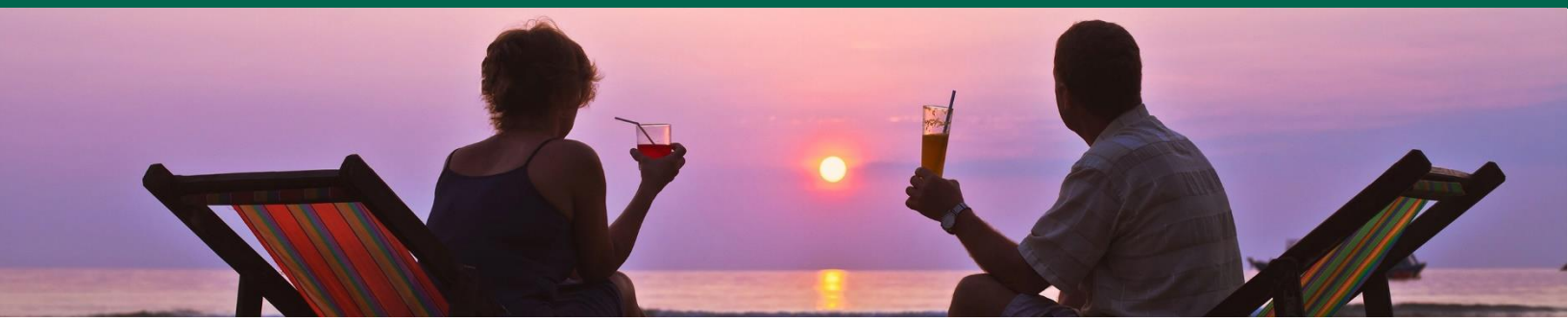
Retirement



Provided by: **Ascensus**
Phone: 888-652-8086
Website: https://myaccount.ascensus.com/rplink/account/login

403(b) Retirement Plan

Green Mountain Higher Education Consortium 403(b) Plan ("Plan") has been adopted to provide you with the opportunity to save for retirement on a tax advantaged basis.

Types of contributions. The following types of contributions are allowed under this Plan:

- 1% mandatory employee contributions
- Employee elective deferrals including both pre-tax and Roth Deferrals
- Employer matching contributions
- GMHEC will match your 403(b) contributions 1:2 up to 8%. (i.e. you contribute 2%, GMHEC will contribute 4%)
- Educational sessions with Financial Advisors
- Opportunity to meet one-on-one with a Financial Planner

See Summary Plan Description for more information.

Paid Time Off (PTO)

Paid Time Off (PTO) Includes any time taken for vacation, sick time, personal time, etc. In addition GMHEC is closed on the following holidays:

- New Year's Day
- Juneteenth OR Martin Luther King
- Memorial Day
- July 4th
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Day
- Winter Break (4 days between Christmas and New Year's)

Paid Time Off starts immediately, if scheduled to work at least 25 hours per week, and accrues each pay period.

Completed Full Years of Services	Accrual Factor (Hourly)	Annualized Accrual (Days)
Less than Two Years	0.0846	22
2	0.0885	23
3	0.0923	24
4	0.0962	25
5	0.1000	26
6	0.1038	27
7	0.1077	28
8	0.1115	29
9	0.1154	30
10	0.1192	31
11	0.1231	32
12	0.1269	33
13	0.1308	34
14	0.1346	35
15	0.1385	36

Important Notices

New Health Insurance Marketplace Coverage Options & Your Health Coverage—ACA Exchange Notice

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

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for

a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as Jan. 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% percent of your 2024 household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

The Affordable Care Act – Medical Loss Ratio (MLR) Rule

The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

Women’s Health and Cancer Rights Act of 1998

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, 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
- Treatment of physical complication of the mastectomy, including lymph edema

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under this plan. Please review your group health plan summary plan description for details of the Plan’s deductible and co-payment requirements for mastectomies. If you would like more information on WHCRA benefits, please call BlueCross BlueShield.

Newborns’ and Mother’s Health Protection Act (NMHPA)

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). For additional information regarding this coverage, refer to the Summary Plan Description (SPD).

Notice of Privacy Practices

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

Our Company's Pledge to You This notice is intended to inform you of the privacy practices followed by the Green Mountain Higher

Education Consortium Health Plan and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on January 1, 2017.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Green Mountain Higher Education Consortium requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information: Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information: Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment: We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations: We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment: Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

***As permitted or required by law*:** We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

***Pursuant to Your Authorization*:** When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

***To Business Associates*:** We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

***To the Plan Sponsor*:** We may disclose protected health information to certain employees of Green Mountain Higher Education Consortium for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

***Right to Inspect and Copy*:** In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

***Right to Amend*:** If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

***Right to an Accounting of Disclosures*:** You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

***Right to Request Restrictions*:** You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address

***Right to be Notified of a Breach*:** You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice: If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities: We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Special Enrollment Notice

This notice is being provided to insure that you understand your right to apply for group health insurance coverage.

You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage: If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Medicaid or CHIP: If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

If you have any questions or complaints, request special enrollment, or obtain more information, please contact:

peopleservices@gmhec.org

Employee Rights and Responsibilities Under the Family and Medical Leave Act (FMLA)

Basic Leave Entitlement: FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements: Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service- member during a single 12-month period. A covered service member is:

(1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*
*The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".

Benefits and Protections During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements: Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.
*Special hours of service eligibility requirements apply to airline flight crew employees.

Definition of Serious Health Condition: A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave: An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave: Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities: Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30-days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities: Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
interfere with, restrain, or deny the exercise of any right provided under FMLA; and discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement: An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.
FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.
FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures..

Your Rights and Protections Against Surprise Medical Bills

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

What is "balance billing" (sometimes called "surprise billing")?

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

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

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

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

If you believe you've been wrongly billed, you may contact the No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

Visit https://www.cms.gov/files/document/memo-no-surprises-act-phone-number-and-website-url-clean-508-mm2.pdf for more information about your rights under federal law.

Michelle's Law

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school In such a case, the Plan must continue to treat the child as eligible up to the earlier of:

The date that is one year following the date the medically necessary leave of absence began; or the date coverage would otherwise terminate under the Plan.

For the protections of Michelle's Law to apply, the child must:

Be a dependent child, under the terms of the Plan, or a participant or beneficiary, and

Have been enrolled in the Plan, and as a student at a post-secondary educational institution,

Immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the Plan.

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

Contact Information

Refer to this list when you need to contact one of the benefit vendors.
For general information, contact The Benefits Team.

Medical Benefits provided by MVP Policy #: 431316 Phone: 888.687.6277 Website: https://www.mvphealthcare.com/	
Vision provided by VSP Policy #: 30082365 Phone: 800.877.7195 Website: https://www.vsp.com	
Dental Benefits provided by Northeast Delta Dental Policy #: 70738-1000 Phone: 800.832.5700 Website: https://www.nedelta.com/Home	
Group Life provided by Unum/Provident Policy #: 0751272 Phone: 800.887.2180 Website: https://services.unum.com	
Flexible Spending Account provided by Navia Solutions Phone: (800) 669.3539 Website: https://app.naviabenefits.com/app/#/login	
Health Savings Account provided by Health Equity Policy #: 77015704 Phone: (866) 346.5800 Website: www.healthequity.com	
EAP provided by InvestEAP Phone: 1-866-660-9533 Website: https://www.investeap.org/	
Wellness provided by The Edge Phone: 802.658.0002 Website: https://edgevt.com/	
Retirement provided by Newport Group Phone: 844.749.9981 Website: https://www.newportgroup.com	

Green Mountain Higher Education Consortium

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802.443.5485

Hickok & Boardman HR Intelligence

802.488.8728
346 Shelburne Road, 5th Floor
Burlington, Vermont 05402

Contact us for assistance with benefits, or claims issues that you have been unable to resolve with the carrier's customer service.