Overview

- Add, drop or change your UVM benefits during Open Enrollment. Open Enrollment begins on November 3 and ends on November 26 this year.

- The month of November is the only time you can change the medical, dental, life and disability insurance components of your benefits package—unless you experience a qualifying life change event.

Important Notes

Contact the HRS Employee Information Center immediately with any life change event (birth, death, adoption, divorce, marriage, graduation, etc.). **You must report a life change event within twenty days of the event** in order to enroll or maintain eligibility for coverage. Call 656-3150 or e-mail hrsinfo@uvm.edu.

The coverage and rates highlighted in this publication begin January 1, 2015 and end December 31, 2015.

If you wish to enroll in a Flexible Spending Account for 2015, you must enroll during this Open Enrollment period. In addition, Cultural Holidays for next year must be designated during the month of November.

UVM Medical Group faculty may change life and LTD coverage during Open Enrollment. They also may change medical and dental coverage by completing paperwork for BOTH employers (e.g., to switch to UVM medical, complete UVM paperwork to add coverage and FAHC paperwork to terminate coverage). Questions? Call UVM HRS at 656-3150.

Changes You Can Make Now

You can make the following adjustments to your UVM insurance coverage during the month of November:

- Add/update/waive medical and/or dental coverage
- Change your dental option to base or high option
- Adjust your life insurance coverage
- Add a dependent to your life insurance coverage
- Change your long-term disability coverage
- Enroll in a Flexible Spending Account

Qualified Dependent Children

For medical coverage purposes only, qualified dependent children are covered until the end of the month of their 26th birthday, however, for dependent dental and life insurance, qualified dependent children are covered until the end of the month of their 19th birthday or their marriage, whichever occurs first. Eligibility for dental and life insurance may be extended beyond a child’s 19th birthday to his/her 24th birthday, if the child is otherwise eligible and is a full-time student. (See the plan documents for details.)

Delta Dental mails out Dependent Verification Request forms when a child over the age of 19 visits the dentist. Failure to complete the form and return it to the address provided on a timely basis will result in the termination of coverage until the next open enrollment period.

Calendar Year 2015 Changes

Employee maximum contributions for 403(b) and 457(b) Retirement Savings Accounts will increase for calendar 2015. See page 7 for more information. This is the only significant change to UVM benefits.

Quick Links to Information

- Calendar Year 2015 Changes
- Qualified Dependent Children
- Medical Insurance Coverage
- Procedures Requiring Approval
- Prescription Drug Coverage
- Waiver of Medical Coverage
- Medical Insurance Premium Rates
- Children’s Health Insurance Program
- Dental Insurance Coverage
- Retiree Health Savings Plan
- Healthcare Programs/Mandates
- Term Life Insurance
- Flexible Spending Accounts
- Long-Term Disability Insurance
- UVM Retirement Savings Plan (RSP)
- Roth Contributions to RSP
- Questions and Answers
- Next Steps

Review Your Benefits

PeopleSoft HR > Self Service > Benefits > Benefits Summary
Medical Insurance Coverage

VHP Open Access Plan

This plan is a point-of-service managed care plan through Blue Cross and Blue Shield of Vermont (BCBSVT). Participants in Vermont and western New Hampshire must select a Primary Care Provider (PCP), but no referrals are required for specialty care. Participants will receive most of their care from a regional network of physicians and will pay reasonable copays with relatively low deductibles. Benefits include:

- Worldwide Access to the BlueCard Preferred Provider Organization Network for all members
- High quality Vermont Collaborative Care management for mental health care
- Low copays for primary care physicians, specialists and cross-covering physicians

Participants pay a $10 copay to see their primary care provider (PCP) and a $20 copay to see a specialist. Emergency Room care has a $50 copay per visit that is waived if followed by hospitalization. There is a copay of $250 for each hospitalization with a maximum of three copays per family per plan year. This copay is for an entire course of treatment; if one is readmitted to the same hospital for the same diagnosis or treatment within 21 days of being discharged, there is no additional copay. Outpatient surgical benefits have a copay of $100 and ambulance services have a copay of $50; prior approval is required for non-emergency transport.

Participants outside of Vermont and western New Hampshire are not required to select a PCP, but all participants must use the Blue Card PPO Network. When using a general or family practitioner, pediatrician, internal medicine practitioner, naturopath or osteopath who is a member of the network, you will pay the PCP rate of a $10 copay per visit. Find a network PCP at www.bcbsvt.com/member/Find_A_Doctor/index.html.

With prior BCBSVT approval, you may choose an out-of-network doctor or hospital. However, you will incur a $500 per person deductible ($1,000 family maximum), after which you will pay 30% of the allowed cost until you have met a $2,500 out-of-pocket maximum ($5,000 family maximum), after which you will be reimbursed 100%.

The VHP Open Access Plan covers many in-network evidence-based preventive services at no cost to members. You can learn more about preventive benefits online.

You may access ten visits for mental health and substance abuse before being pre-certified by Vermont Collaborative Care. After the initial ten visits, pre-certification is required. Under the VHP Open Access plan, in-network services are covered at no cost to the participant.

--- The Fine Print ---

This information is designed to summarize new features that have been added to the benefits package during the past 12 months—or that will be added on January 1, 2015. This document is not intended to provide complete details for each benefit. Full descriptions of insurance benefits are contained in plan documents or subscriber certificates (in conjunction with the UVM Non-Represented Faculty Handbook, the University and University Officers’ Manual, or the UVM Staff Handbook). Before making changes to coverage, employees are encouraged to familiarize themselves with their insurance benefits at the links above.

Information presented here is intended for faculty and staff who are not represented by unions. Collective bargaining unit employees are subject to the terms and conditions of employment outlined in union contracts.

For unionized employees, benefits are addressed through collective bargaining with union representatives. Represented employees must contact their union representatives with their questions and comments regarding changes in benefits. All employees, however, may contact their supervisors or the HRS Employee Information Center to seek clarification or ask questions regarding existing benefits programs.
Medical Procedures Requiring Approval

BCBSVT does not require a referral to see a specialist. You may visit any specialist within the network—except in the case of the following medical procedures that require prior approval:

1. Early childhood development disorders, including autism
2. Plastic or cosmetic surgery (e.g., abdominoplasty, lipectomy, blepharoplasty, breast reconstruction, otoplasty, panniculectomy, rhinoplasty or septrhinoplasty)
3. Dental surgery (oral surgery, trauma, orthognathic surgery)
4. Chiropractic care after initial 12 visits in a calendar year
5. Special radiological procedures (MRI, MRA, MRS, PET scans)
6. UPPP/somnoplasty
7. Continuous Passive Motion (CPM) equipment
8. Durable Medical Equipment with a purchase price over $1,000
9. Orthotics/prosthetics
10. Polysomnography (sleep studies)
11. Chondrocyte transplants
12. Home infusion therapy
13. Private duty nursing
14. Transplants
15. TENS units/neuromuscular stimulators
16. Rehabilitation (cardiac/pulmonary/inpatient rehabilitation facility) services by any out-of-network provider

Prescription Drug Coverage features a $100 deductible, after which participants pay $5 per generic prescription, $20 per preferred prescription, or $40 per non-preferred prescription ($5/20/40). Prescription drug coverage has a maximum out-of-pocket expense of $1,250 for individuals and $2,500 for a family. A mail order prescription drug plan is available for maintenance drugs through Express Scripts. (Visit their website or call 888-222-7886.) Purchase a 90-day supply at a cost equal to two copays (i.e., $10/40/80), with no deductible. See the full preferred prescription drug list online.

Step Therapy encourages members to try lower cost, generic medication before newer, more expensive alternatives. Visit the BCBSVT online Prescription Center for information.

Prescription Claims through network pharmacies or Express Scripts mail order are automatically filed with Blue Cross at the time of purchase. You must submit non-network claims directly to BCBSVT via a prescription claim form.

Waiver of Medical Coverage

UVM offers an annual $1,000 payment in lieu of medical coverage. This waiver is reimbursed over the course of the year and is subject to income tax withholding. The waiver is available to any full-time employee who certifies that s/he and, if applicable, his/her dependents are covered by non-UVM medical insurance. (A full-time employee is defined as anyone who is employed at 75% full-time equivalency [FTE] or more on a 12-month basis, or at 100% FTE on a 9, 10 or 11-month basis.)

The waiver of medical coverage is not available to faculty or staff whose spouse also works at UVM, nor is it available to an individual who has retired from UVM with post-retirement benefits. Further, it is not available to faculty or staff who waive coverage for eligible dependents but not for themselves, nor is it available to spouses of UVMMG physicians who have healthcare coverage through Fletcher Allen Health Care.

If you lose your non-UVM medical insurance by an event outside your control, you are eligible to enroll in a UVM medical plan within 20 days of the date of the event. If you waived coverage for yourself and your dependents, and your spouse loses employment, or if you lose coverage because of divorce or your spouse’s death, you may enroll in the UVM plan within 20 days of the date of the event, as long as you provide appropriate documentation.

If you elect to waive medical insurance coverage, you are required to complete an annual written certification form each November, attesting that you are covered with two-person or family coverage through your spouse or civil union partner. Certification must be returned to the HRS Employee Information Center, 228 Waterman Building. Failure to provide the required annual certification will make you ineligible for the waiver payment.
**Medical Insurance Premium Rates**

**Medical insurance premium rates will not increase during calendar year 2015.**

Medical insurance premium rates and comparison charts are provided on the HRS website. The salary used for figuring your cost of insurance is your base salary on January 1 of each year. Your rate will not be affected by salary changes during the year, unless you have a job or FTE change.

For College of Medicine faculty, base salary includes the combined salary paid under the common paymaster. Employees with 9, 10 or 11-month appointments pay their share of annual premiums in keeping with how they receive their pay. For example, a 9-month faculty member who gets paid over 9 months will pay for their 12-month coverage over the 9-month term (18 paychecks).

Part-Time non-represented faculty and staff are eligible to receive UVM contributions if their full-time equivalency is at least 50%, and they have been employed for at least two semesters if faculty, or for one year if staff.

Part-Time Premiums are based on the employee’s full-time equivalency. For example, an employee who works 60% FTE pays 40% of the cost of coverage. Part-time employees who are at least 50% FTE but do not meet the length of service requirement may enroll if they pay the full cost of coverage.

**Medicaid/Children’s Health Insurance Program (CHIP)**

If you are eligible for health insurance coverage through your employer but are unable to afford the premiums, some states (including Vermont) have premiums assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state that provides assistance, contact your state Medicaid or CHIP office to find out if you qualify.

If you or your dependents are not currently enrolled in Medicaid or CHIP and you think that you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial 1-877-KIDS-NOW or visit www.insurekidsnow.gov to find out how to apply. If you qualify, you can determine whether your state has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan must permit you and your dependents to enroll in the plan—as long as you and they are eligible, but not already enrolled in the plan. This is called a “special enrollment” opportunity and you must request coverage within 60 days of being determined eligible for premium assistance.

Check www.insurekidsnow.gov/state/index.html for more information on the states that participate. (Dr. Dynasaur is the CHIP plan for the state of Vermont.)

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**Medical and Dental Insurance Premium Costs**

**Employee/Employer Premium Costs from January 1 through December 31, 2015:**

| Plan                                | Cost                                      
|-------------------------------------|-------------------------------------------
| BCBSVT VHP Open Access Plan         | No Increase                               
| Delta Dental Plan                   | No Increase                               
| Standard Life Insurance             | No Increase                               
| Standard LTD Insurance              | No Increase                               

**Employee’s Monthly Cost for the High Option Dental Plan:**

| Coverage                          | Cost  
|-----------------------------------|-------
| Employee Only                     | $7.00 per month  
| Employee and Spouse               | $14.00 per month  
| Employee and Child(ren)           | $14.50 per month  
| Employee and Family               | $21.50 per month  

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### Dental Insurance Coverage

UVM offers **two dental plans** through Northeast Delta Dental: the **Base plan** and the **High Option plan**. See the chart.

Two separate networks are available to UVM through Northeast Delta Dental. In addition to the Delta Dental Premier network, participants can select dentists who are part of the Delta Dental PPO network. Delta Dental PPO network dentists often accept lower fees for services, which may mean savings for patients.

Full-time employees are eligible for dental coverage after a six-month waiting period. UVM pays the full Base plan premium for full-time employees and dependents. If you select the High Option plan, you pay the difference in premium cost between the Base and High Option plans. **The premium rate for the High Option dental plan will not increase during calendar year 2015.**

**Dental coverage for part-time employees** is available after one year of service for staff and after twenty-four months for faculty. For the Base plan, UVM will contribute a percentage equal to the employee’s FTE. For the High Option plan, the employee pays the difference in premium between the Base and High Option plans, in addition to his/her share of the Base plan premium.

If you currently have dental insurance coverage and do not wish to make any changes, no action is necessary. However, if you wish to switch between the base and high option plans, you may do so during Open Enrollment. Also, if you previously waived coverage and now wish to enroll, you may do so during Open Enrollment. Coverage will be effective on January 1. For further information about dental coverage, visit the [Delta Dental](#) website.

#### Coverage Provided by the Dental Plans

<table>
<thead>
<tr>
<th></th>
<th>Base Plan</th>
<th>High Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage A (Preventive)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Coverage B (Minor Restorative)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Coverage C (Major Restorative)</td>
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<td>60%</td>
</tr>
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<td>$25</td>
</tr>
<tr>
<td>Deductible/Family/Calendar Year</td>
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<td>$75</td>
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</tr>
<tr>
<td>Maximum/Person/Calendar Year</td>
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<td>$1,500</td>
</tr>
<tr>
<td>Coverage D (Orthodontics)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Lifetime D Maximum/Person</td>
<td>$500</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

**Note:** Out-of-pocket maximums through Northeast Delta Dental run through the calendar year, not the fiscal year.

### Retiree Health Savings Plan

UVM maintains a Retiree Health Savings Plan (RHSP) to help individuals pay for qualified healthcare expenses during retirement. UVM makes regular tax free contributions to the plan for benefits-eligible faculty and staff hired on or after January 1, 2012. Although the plan is intended for those hired on or after January 1, 2012, all active benefits-eligible faculty and staff regardless of hire date may establish an RHSP and make regular, voluntary after-tax contributions.

For eligible faculty and staff hired after January 1, 2012, UVM contributions are automatic. Those hired on or after January 1, 2012 who wish to make **personal** contributions, and those hired before January 1, 2012 who wish to establish a Retiree Health Savings Plan, must complete the RHSP [Election Form](#). For more information, see the [RHSP web page](#).
State and Federal Healthcare Programs and Mandates

Here’s a brief description of the key state and federal mandates:

- **Vermont Vaccine Purchasing Program** provides vaccines to participating providers at no cost.

- **Vermont Early Childhood Development Disorders Mandate** is an expansion of last year’s “Vermont Autism Mandate.” This expanded program provides coverage for the treatment of a broad spectrum of early childhood developmental disorders from birth until an individual’s 21st birthday.

- **Vermont Prescription Cost Sharing Mandate** lowers the maximum allowable employee/family out-of-pocket prescription cost from $1,300 to $1,250 for single coverage and from $3,800 to $2,500 for family coverage.

- **Federal Women’s Preventive Services Mandate** expands the services to be covered with no individual copay. Well-women visits, screening for gestational diabetes, HPV testing, counseling for STIs and HIV, contraception, lactation support/supplies, and screening/counseling for domestic violence are all included under this provision.

- **Federal Patient-Centered Outcomes Research Trust Fund Fee** will be used to sponsor research in patient-centered outcomes.

- **Federal Insurer Fee** is an assessment aimed at funding the health exchanges.

- **Federal Transitional Reinsurance Fee** funds the reinsurance program for high-cost claimants in individual plans.

Term Life Insurance

There are no changes in rates or plan design for term life insurance for calendar year 2015.

UVM offers the opportunity to purchase up to seven times your UVM base salary ($1,000,000 maximum) in life insurance for yourself, up to one half the employee covered amount ($200,000 maximum) for your spouse, and $10,000 for each covered child. During the month of November, you may increase your coverage (up to the limits) or add a child if you haven’t already elected to do so, as long as you provide proof of good health to The Standard Insurance Company. An increase in life insurance coverage can only be made during Open Enrollment.

Flexible Spending Accounts

Many people realize significant savings on their income tax through the wise use of a Flexible Spending Account (FSA) for health care and/or dependent care expenses. In order to participate in calendar year 2015, **you must enroll now, before the November 26, 2014 deadline**. If you are currently enrolled for this year, please note that YOU MUST SUBMIT NEW enrollment forms for 2015.

FSA allows you to set aside dollars from your paycheck before tax in order to pay for certain health care and/or dependent care expenses tax free. Be aware that you MUST USE the money you set aside, or you will LOSE IT.

**Dependent Care Account** may be used for such things as:

- daycare
- before and after school care
- elder care
- care of a disabled spouse

**A Health Care Account** may be used for such things as:

- medical and dental co-pays
- orthodontics
- insurance deductibles
- hearing and vision expenses
- approved over-the-counter medications **with a doctor’s prescription**
Important Flexible Spending Account Reminder. When determining how much to contribute to your Medical and/or Dependent Care Flexible Spending Accounts, be aware that federal law requires you to **forfeit any unused funds remaining in your account(s) at the end of the plan year.**

Participants are now able to roll over up to $500 of unclaimed funds in a Flexible Spending Account for healthcare into a new account for the next calendar year. (Any amount over $500 will still be subject to the "use it or lose it" rule.) The federal government is only allowing the rollover of funds in a flexible spending account for healthcare. Funds in a dependent care account cannot be rolled over.

**Example:** Jennifer set aside $2,550 in a flexible spending account to cover healthcare expenses for herself and her two daughters during the calendar year. For a variety of reasons, her healthcare expenses are much lower than she anticipated and by December 31 she has only $1,950 worth of eligible expenses. In this scenario, Jennifer will be able to roll over $500 into a new FSA to reimburse healthcare expenses incurred in the next calendar year and she will forfeit $100. For more information, visit our Flexible Spending Account site at [www.uvm.edu/hrs/flex](http://www.uvm.edu/hrs/flex).

As a reminder to those currently participating in an FSA, all claims for 2014 must be submitted to EBPA, the Plan Administrator—not to UVM—by March 31, 2015. Claims may be submitted through the online portal, as well as by mail or fax. See the Flexible Spending Account site at [www.uvm.edu/hrs/flex](http://www.uvm.edu/hrs/flex).

Federal legislation sets the amount you will be able to set aside for approved medical expenses at **$2,550 for 2015.** Recent legislation eliminated reimbursement for over-the-counter medications and medical supplies, except with a prescription. For a list of the sorts of things that are covered, see the resources on the [HRS Flex Spending page](http://www.uvm.edu/hrs/flex).

### Long-Term Disability Insurance

The Standard Long-Term Disability Plan provides long-term disability coverage with **no changes in rates or plan design.**

You are eligible for disability insurance coverage if you have completed at least one year of service and are employed 75% FTE on a 12-month basis, or 100% FTE on a 9, 10 or 11-month basis. **You must enroll within 20 days of your eligibility date, or provide proof of insurability to enroll during Open Enrollment in the month of November.**

You may request a change in coverage due to a major life event (e.g., gain or loss of a dependent, or termination of your spouse's full-time employment). A change will only be allowed if you apply within **20 days** of the life event.

You may check PeopleSoft HR Self-Service (Benefits > Benefits Summary) to see whether you have purchased 60% or 70% LTD coverage. If there is no deduction for disability insurance on your paycheck, you are not covered.

### UVM Retirement Savings Plan

Participants in the UVM Retirement Savings Plan may contribute up to 100% of their compensation, minus their benefit costs (i.e., FICA and Medicare taxes, health and dental deductions, etc.) **to a limit of $18,000 in calendar year 2015.** Salary reduction forms ([available here](http://www.uvm.edu/hrs/flex)) should be submitted annually (ideally in January) for those making catch-up contributions, in order to spread contributions over the greatest number of payroll checks.

If you come to UVM from another organization where you contributed this year to either a §403(b) plan or a SEP or an IRA or a §401(k), those contributions must be added to your contributions to UVM's plan when determining your maximum contributions for this year. The sum of all such contributions cannot exceed $18,000 in 2015 if you are 49 years of age or younger, or $24,000 in 2015 if you are 50 years of age or older. (The amounts are subject to change annually by the IRS.)

Participants who wish to contribute more than the maximum elected deferral amount listed above have two programs that may be available to them:

1. **Special §402(g) Years of Service Catch-Up** and/or

2. **Age 50+ Catch-Up**

**Salary reduction forms for the catch-up options should be submitted annually** (ideally in January) in order to spread out your contribution over the greatest number of payroll checks.

Participants age 50 and over on December 31, 2015, may contribute an additional $6,000 to the plan in calendar year 2015. For each year you wish to use catch-up provisions, you must complete a **Salary Reduction/Investment Agreement.** You will find this agreement in the [Forms](http://www.uvm.edu/hrs/flex) area of the HRS website.
Roth Contributions to UVM 403(b) Retirement Savings Plans

The University accepts §403(b) Roth contributions to your retirement savings account(s). These after-tax contributions are simply another way to contribute money to your account(s). Instead of having all of your contributions deducted from your paycheck before taxes, you may decide to make additional contributions to a Roth account on an after-tax basis. Later, if you meet certain requirements, the Roth money you withdraw at retirement may be “qualified,” meaning it will be federal income tax free. Here are a few points to keep in mind:

- You may make §403(b) Roth contributions regardless of your income.
- Roth contributions are subject to income taxes in the year in which they are contributed, and they will be reflected on your W-2 for that year.
- Your total elective deferral to the plan (including both before-tax contributions and Roth contributions) cannot exceed the elective deferral limits set by the IRS on an annual basis.
- You can change the amount of your ongoing before-tax or Roth contributions anytime.
- You cannot “reclassify” an existing before-tax balance as a Roth balance.
- Required minimum distribution rules apply to Roth contributions. This means you generally must begin taking distributions from your account during the year in which you reach age 70½.
- Employer contributions are not permitted in your Roth account. To continue to receive the University contributions, you must make your (2 or 3%) minimum contribution to your before-tax account.
- Roth money you withdraw at retirement may be “qualified” and thus not be subject to federal income tax. To be “qualified,” the distribution must:
  - Generally happen at least five years after your first Roth contribution and,
  - Occur after you reach age 59½ (or after your death or disability as defined by federal tax law).

If your withdrawal does not meet these qualifications, the earnings will be taxable; additionally, if you are under age 59½, any distribution of funds will be subject to an early distribution penalty.

--- Catch-Up Options ---

The Special §402(g) years of service catch-up option is only available to those employees with 15 or more years-of-service with UVM. You must have fifteen years of full-time equivalent service with UVM and your elective deferrals cannot average more than $5,000 per year of credited service. Under this Special §402(g) years of service catch-up, you would be eligible to make up to a $3,000 annual catch-up contribution ($15,000 lifetime maximum). The Special §402(g) years of service catch-up calculation form must accompany each reduction form.

To be eligible for the Age 50+ catch-up contribution in a calendar year, you must be at least age 50 by December 31 of that year, must have elected to defer the maximum regular reductions as adjusted for cost-of-living, and must not be eligible for Special §402(g) years of service catch-up. Age 50+ catch-up is limited to $6,000 for 2015.

You can use both the Special §402(g) years of service catch-up and the Age 50+ catch-up option during the same year, but you must use the ordering rule which requires that you apply all catch-up to the Special §402(g) years of service rule first, then apply any excess contributions to Age 50+ catch-up. Contact HRS for assistance.
Questions and Answers

What if I'm happy with my current coverage and benefits choices?

If you are satisfied with your current coverage, it will continue without any action on your part. (Unless you are waiving medical coverage, in which case you must complete a Waiver of Medical Coverage during Open Enrollment.)

How can I tell which insurance coverage I've selected?

Log in to PeopleSoft HR and navigate to Self-Service > Benefits > Benefits Summary.

If I don't change my benefits now, can I make changes later in the year?

You can only make changes to your medical, dental, life and long-term disability insurance during Open Enrollment in November, unless you experience a qualifying life change event (birth, death, adoption, divorce, marriage, graduation, etc.). Review all your benefits to ensure that you are taking advantage of the best benefits for your particular situation.

Note: Changes to your retirement plan can be made any time during the year. Contribution and vendor changes are made through HRS; allocation changes are made through your retirement account vendor.

Where can I find a description of the various benefit plans?

See the HRS website under Info for Faculty and Staff > Benefits > Benefit Plans.

I understand that medical coverage has been extended to dependents through the age of 26. Is that true?

Yes, as a result of the federal legislation that was adopted in 2010, access to medical coverage may now be extended to qualifying dependents through the age of 26. This is only the case for medical coverage, not for dental or life coverage—see the information above under Dental Insurance Coverage.

My dependent child is graduating from college this spring. When will her DENTAL coverage end?

Recognize that the guidelines for dental coverage are different than the guidelines for medical coverage: If your dependent is not a full-time student, her DENTAL coverage will end on her 19th birthday. If she is a full-time student, she is eligible for dental coverage on your policy until her 24th birthday, or until she ceases to be your dependent, or until she ceases to be a full-time student, whichever happens first. Dental coverage will terminate at the end of the month in which she either graduates, ceases to be your dependent, or turns 24. You must notify the HRS Employee Information Center within 20 days of the first of these events or your COBRA options will be limited.

My dependent child is in graduate school this spring. When will his MEDICAL coverage end?

He may stay on your medical coverage until his 26th birthday, whether or not he is in school and whether or not he is married. You must notify the HRS Employee Information Center within 20 days of your child’s 26th birthday or his COBRA options will be limited.

Every year I receive a notice from my dental insurance company asking me to certify that my dependent child is a full-time student. After completing the form, what should I do with it?

Delta Dental seeks to verify the student status of children between the ages of 19 and 24 when they process a claim for that child. If you receive a Delta Dental dependent certification form, it should be returned directly to Delta Dental.

I've heard about the availability of an “SBC.” What is that?

The Summary of Benefits and Coverage (SBC) is a document that communicates details about a healthcare plan in a standardized format so that one can more easily compare plans. Find your SBC at www.uvm.edu/hrs/sbc.

What's the most important thing to remember?

In order to make changes to your UVM benefits, be sure to complete the necessary paperwork during the Open Enrollment period in the month of November. Open Enrollment ends at 4:30 PM on Wednesday, November 26th.
Next Steps

1. Check your current benefits enrollment status.
   Consult PeopleSoft Human Resources > Self Service > Benefits > Benefits Summary

2. Review the available options and changes effective January 1. See the HRS website for more information.

3. If you are satisfied with your current coverage, it will continue without any action on your part. (Unless you are waiving medical coverage, in which case you must complete a Waiver of Medical Coverage.)

4. If you wish to make changes to your coverage, complete and submit the appropriate paperwork before November 26th. Forms may be found under Forms on the menu of the HRS web site.

For more information, see the Info for Faculty and Staff area of the HRS website for information about:

- Benefit Plans
- Benefit Eligibility
- Medical and Dental Premiums
- Long-Term Disability Rates
- Total Compensation

Questions about benefits? e-Mail HRSInfo@uvm.edu