2026 Benefits Guide

UCONN HEALTH | Community Network

Inside This Guide

Welcome to Your Benefits!

Our Commitment

UConn Health Community Network has a vision – to be recognized for the quality of service we provide and lead our industry in customer satisfaction. To succeed, we remain committed to hiring and retaining the best, most talented employees for our business.

UConn Health Community Network fosters an environment where your contributions can be appreciated and recognized. We want to make a difference and ultimately build a fulfilling and rewarding career with you.

Choose the Coverage that's Right for You!

This Employee Benefits Guide provides essential information about the benefit plans available to eligible employees and their families. These plans prioritize your health and well-being.

The goal is to make a difference in your life and career so you can make a difference in the lives of others. No matter where you are, the plans sponsored by UConn Health Community Network will be with you every step of the way.

Our employee benefit program is designed to cover many of life's most concerning contingencies – health care, prescription drugs, dental treatment, loss of income through disability insurance and family financial protection. These are issues we all must address to have a sense of personal and family security. Each of the benefit selections is summarized throughout this benefit summary guide. More detailed information on each benefit, important benefits information such as the HIPAA Notice of Privacy Practices, uniform summary of benefits, Summary Plan Descriptions, and related forms are available through our internet based Benefits Administration System, Oracle.

Eligibility

Eligibility for benefits is determined by employee classification, number of hours scheduled to work and a waiting period before benefits are effective.

	Eligibility for Benefits	
Employee Classification	Full-time employees	Part-time employees
Hours Requirement	36-40 hours/week	20-35 hours/week
Waiting Period (benefits effective date)	1st of month following 30 days of continuous employment	
Benefits Offered	■ Medical / Prescription Drugs ■ Dental ■ Vision ■ Flexible Spending Accounts (FSA) ■ Basic Life / AD&D ■ Employee Assistance Program (EAP) ■ Optional Life ■ Spouse Life ■ Child Life ■ Disability ■ Identity Theft Protection	■ Medical / Prescription Drugs ■ Dental ■ Vision ■ Flexible Spending Accounts (FSA) ■ Basic Life / AD&D ■ Employee Assistance Program (EAP) ■ Optional Life ■ Spouse Life ■ Child Life ■ Disability ■ Identity Theft Protection
When Benefits Terminate	Medical, Dental, Vision, and FSA benefits end the last day of the month; all other benefits end the date of termination	

Dependent Eligibility

Your eligible dependents also have access to many of the benefits we offer. Eligible dependents include:

- Legal spouse who is not eligible for coverage under their employer's health plan.
- If your legal spouse is enrolled or eligible for medical insurance through another group health plan, they are not eligible to be covered under medical, dental or vision benefits.
- Children up to age 26, including natural children, stepchildren, legally adopted children, children for whom you are the legal guardian, foster children, children for whom you are legally responsible to provide health coverage under a Qualified Medical Child Support Order (QMCSO).
- Disabled children over age 26 if unmarried, incapable of self-support, dependent on you for primary support and the disability occurred before the age of 26.
- Babies born to dependent children are not covered.
- You may be required to provide supporting documentation, such as a marriage certificate, 1040 tax form, or birth certificate to verify dependent eligibility.

When You Can Enroll or Make Changes

Newly hired employees have the opportunity to enroll during the eligibility waiting period. Eligible employees may also enroll or make changes to their benefits during the annual open enrollment period. Once elections are completed, no changes can be made until the next annual Open Enrollment period unless you experience a qualifying event status change or life event, such as:

- Marriage, divorce, or legal separation
- Birth, adoption or change in custody of eligible dependent
- Change in eligibility or employment status (i.e., benefit ineligible to benefit eligible, FT to PT and PT to FT)
- Change in your married partner's employment status
- Gain or loss of eligibility for a dependent due to age change
- Loss of other health coverage (i.e., married partner's health plan coverage begins or ends or Medicare / Medicaid eligibility ends)
- Legal decree, judgment or order (i.e., Qualified Medical Child Support Order – QMCSO)

You must notify the Benefits Department of any family or employment status changes within 31 days of the status change. This includes divorce or legal separation so the former spouse is removed from insurance. Failure to do so will result in delay of change until the next annual Open Enrollment period.

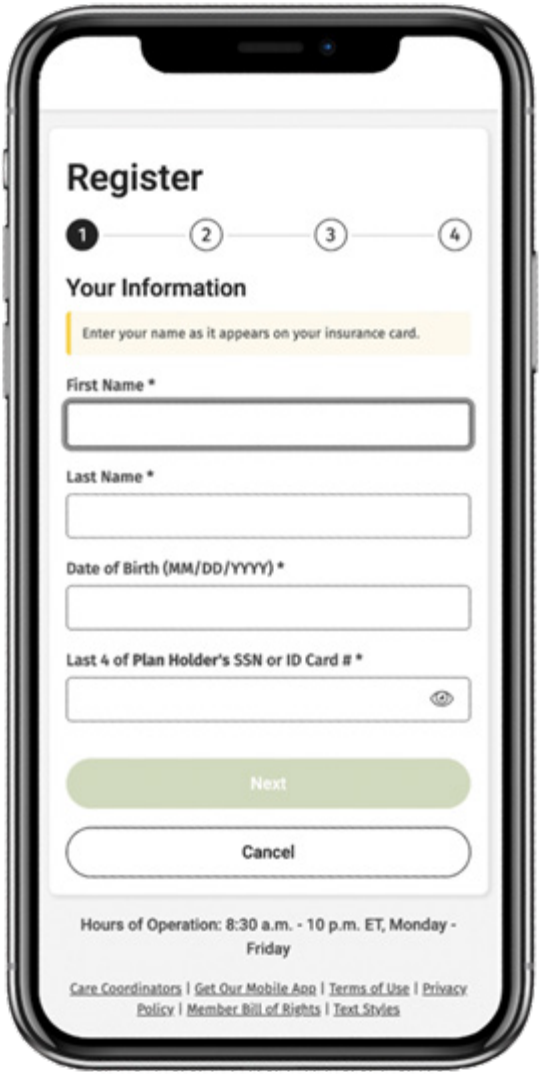
Quantum Health

Administered by Quantum Health

If there's a better way for you to experience healthcare, Quantum Health will find it.

Think of Quantum Health as your personal benefits assistants comprised of nurses, benefits experts, and claims specialists who will do all they can to support your unique healthcare and benefits needs. Each time you contact Quantum Health you'll talk to a real person who can help with:

- Finding in-network providers
- Providing guidance and advice for new diagnoses or illnesses
- Handling confusing claims and bills
- Obtaining a pre-certification for a hospital stay, test or procedure
- Verifying prescription coverage
- Confirming eligibility for your providers
- Replacing lost ID cards
- Maximizing your benefits
- Answering questions about your care or health plan



Quantum Health, your personal benefits assistant, is just a tap, click or call away!

How to register.

(Partial functionality as of 3/01 – full roll out as of 4/01)

The Quantum Health app and website make managing your healthcare and benefits easier than ever.

1	**Download** the Quantum Health app or go to **www.UCHCN.Quantum-Health.com**.
2	Click on **Register**.
3	**Provide the information** requested. Anything with an asterisk(*) is required. You'll need to provide your first and last name, date of birth and last four digits of the plan holder's Social Security number.
4	Click **Next**.
5	**Set up two-factor authentication** using your email or mobile phone number.
6	**Check for a verification code** that will be sent to your email or phone.
7	**Enter the verification code** to complete your registration.

Medical

We value you and your family's health and well-being. That's why we offer comprehensive medical coverage to provide all the benefits and resources you need to support your health throughout the year.

To better evaluate the coverage and features available to you, please review the following brief summary of benefits.

Your Medical Options

You have a choice of the following plan options:

- EPO
- Limited PPO
- Standard PPO
- Premier PPO
- Value PPO

Selecting a Plan That's Right for You

Choosing the right medical plan takes careful consideration. Before making your decision, be sure to look closely at these factors:

- **Choice:** Some plans offer greater provider and facility networks than others. If you prefer to seek services both in and out of the network, choose a plan that offers higher levels of coverage and gives you the flexibility to select your provider.
- **Coverage:** Whether routine, surgical, prescription or another type of coverage, determine if the plan covers the services and medical treatments you value most.
- **Cost:** Each plan contains a variety of cost components. Consider the amount of your payroll deduction, as well as other plan expenses such as deductibles, copayments or coinsurance.

Medical Benefits EPO

Exclusive Provider Organization (EPO)

The Medical Exclusive Provider Organization (EPO) plan requires that you receive your health care from providers in the Tier 1 Network. The EPO Plan offers a full range of coverage with low out of pocket costs and is designed to be a cost-effective means of obtaining your health care services to protect you and your family in the event of an illness or injury.

All services must be received from providers in the Tier 1 Network when available, regardless of where you reside. If utilizing a Tier 1 Network provider, benefits will be paid based on your covered benefits where you are employed. Out-of-network benefits are only available for emergency services; otherwise the service will not be covered. If services are not available within the Tier 1 Network, you may access care through the Anthem BlueCross BlueShield BlueCard PPO Network (Tier 2). Tier 2 benefits apply when services are rendered by a Tier 2 provider.

	Anthem BlueCross BlueShield EPO	
	Tier 1 **Waterbury Hospital and Affiliates** and UConn Health Community System National Network*****	**Tier 2** **Only for Services Not Available in the Preferred EPO Network******
LIFETIME PLAN MAXIMUM (PER INDIVIDUAL)		
Essential Health Benefits	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Individual	$0	$250
Family	$0	$750
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)		
Individual	$2,750	$2,750
Family	$8,250	$8,250
PHYSICIAN SERVICES		
Office Visit (Primary Care Physician)	$35 copay	
Office Visit (Specialist)	$40 copay	
Surgeon, Assistant Surgeon, Anesthesia	No charge	No charge*
Teladoc (Telemedicine Visit)	$10 copay	
INPATIENT SERVICES - FACILITY		
Inpatient Hospital Room & Board	No charge	$600/admit, then 10%*
OUTPATIENT SERVICES - FACILITY		
Outpatient Lab, X-Ray, Diagnostic	No charge	10%*
Outpatient Surgery	No charge	$300/service, then 10%*
Ambulatory Surgical Center	No charge	$300/service, then 10%*
Hospital-Outpatient Treatment (nonsurgical & other expenses)	No charge	$300/service, then 10%*
EMERGENCY CARE		
Urgent Care	$35 copay	
Emergency Room (copay waived if admitted)	No charge	$170 copay*
Emergency Room Physician	No charge	No charge*
Ambulance	10%	10%*
PREVENTIVE CARE / WELLNESS SERVICES		
Physical Exams and Periodic Check-Ups	No charge	No charge
Well Baby and Well Child Care	No charge	No charge
Well Woman Exams	No charge	No charge
Immunizations	No charge	No charge

Medical Benefits EPO (Continued)

	Anthem BlueCross BlueShield EPO	
	Tier 1 **Waterbury Hospital and Affiliates** and UConn Health Community System National Network*****	**Tier 2** **Only for Services Not Available in the Preferred EPO Network******
OTHER PROVIDER SERVICES		
Physical, Speech & Occupational Therapy (60 combined visits/cal yr)	$40 copay	$40 copay
Chiropractic Care	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Services - Primary Care	$35 copay	$35 copay
Allergy Services - Specialist	$40 copay	$40 copay
Allergy Services - Injections & Serum	No charge	No charge
PREGNANCY AND MATERNITY CARE		
Pre-Natal Care (Initial Visit)	No charge	No charge
Inpatient Hospital Room and Semi Private	No charge	$600/admit, then 10%*
GENERAL MEDICAL SERVICES		
Physician's Office, Lab and X-Ray	No charge after OV copay	OV copay, then 10%
Independent Lab and X-Ray	No charge	No charge*
Advanced Imaging	No charge	$100 copay/test*
Skilled Nursing or Extended Care Facility (up to 100 visits/cal year)	No charge	$100 copay/admit*
Home Health Care (up to 100 visits/cal year)	$35 copay/visit	$35 copay/visit
Hospice Care	No charge	$100 copay/admit*
Durable Medical Equipment	No charge	No charge*
Hearing Aid Services & Ancillary Equipment	No charge, deductible waived $2,000 allowance every 24 months (does not count towards OOP Max)	
MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE		
Inpatient Facility	No charge	$600/admit, then 10%*
Inpatient Physician	No charge	No charge*
Outpatient Visits (physician)	$35 copay	
Prescription Drug Coverage	**Medimpact Mandatory Generic Retail[1]**	
Deductible (Individual/Family)	None	
Out-of-Pocket Max (Individual/Family)	$2,500 / $5,000	$2,500 / $5,000
RETAIL RX (UP TO 30-DAY SUPPLY)		
Generic	$15 copay	
Formulary Brand	$45 copay	
Non-Formulary Brand[2]	$60 copay	
MAIL ORDER RX (90-DAY SUPPLY)		
Generic	$30 copay	
Formulary Brand	$90 copay	
Non-Formulary Brand[2]	$120 copay	
Specialty (30-day supply)	25% ($150 max.)	

Medical Benefits Limited PPO

The Limited PPO plan provides the same provider network as the EPO plan except you are not limited to the Tier 1 network. You have flexibility to use the UConn Health Community System National Network (Tier 1) or the Anthem BlueCross BlueShield Network (Tier 2). Your cost sharing will depend on whether you use Tier 1 or Tier 2 networks. There is no out-of-network coverage unless it is an emergency.

	Anthem BlueCross BlueShield Limited PPO	
	Tier 1 **UConn Health Community System National Network****	**Tier 2** **Anthem BlueCross BlueShield Preferred Network**
LIFETIME PLAN MAXIMUM (PER INDIVIDUAL)		
Essential Health Benefits	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Individual	$0	$1,630
Family	$0	$4,890
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)		
Individual	$2,750	$5,000
Family	$8,250	$10,000
PHYSICIAN SERVICES		
Office Visit (Primary Care Physician)	$35 copay	20%*
Office Visit (Specialist)	$40 copay	20%*
Surgeon, Assistant Surgeon, Anesthesia	No charge	20%*
Teladoc (Telemedicine Visit)	$10 copay	
INPATIENT SERVICES - FACILITY		
Inpatient Hospital Room & Board	$600/admit, then 10%	20%*
OUTPATIENT SERVICES - FACILITY		
Outpatient Lab, X-Ray, Diagnostic	No charge	20%*
Outpatient Surgery	$300/service, then 10%	20%*
Ambulatory Surgical Center	$300/admit, then 10%	20%*
Hospital-Outpatient Treatment (nonsurgical & other expenses)	No charge	20%*
EMERGENCY CARE		
Urgent Care	$35 copay	
Emergency Room (copay waived if admitted)	No charge	20%*
Emergency Room Physician	No charge	No charge
Ambulance	10%	10%*
PREVENTIVE CARE / WELLNESS SERVICES		
Physical Exams and Periodic Check-Ups	No charge	
Well Baby and Well Child Care	No charge	
Well Woman Exams	No charge	
Immunizations	No charge	

* After deductible

** When service is available and based on covered benefits where you are employed.

Medical Benefits Limited PPO (Continued)

	Anthem BlueCross BlueShield Limited PPO	
	Tier 1 **UConn Health Community System National Network****	**Tier 2** **Anthem BlueCross BlueShield Preferred Network**
OTHER PROVIDER SERVICES		
Physical, Speech & Occupational Therapy (60 combined visits/cal yr)	$40 copay	20%*
Chiropractic Care	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Services - Primary Care	$35 copay	20%*
Allergy Services - Specialist	$40 copay	20%*
Allergy Services - Injections & Serum	No charge	20%*
PREGNANCY AND MATERNITY CARE		
Pre-Natal Care (Initial Visit)	No charge	No charge
Inpatient Hospital Room and Semi Private	$600 copay, then 10%	20%*
GENERAL MEDICAL SERVICES		
Physician's Office, Lab and X-Ray	No charge after OV copay	20%*
Independent Lab and X-Ray	No charge	20%*
Advanced Imaging	No charge	20%*
Skilled Nursing or Extended Care Facility (up to 100 visits/cal year)	No charge	20%*
Home Health Care (up to 100 visits/cal year)	$35 copay/visit	20%*
Hospice Care	No charge	20%*
Durable Medical Equipment	No charge	20%*
Hearing Aid Services & Ancillary Equipment	No charge; $2,000 allowance every 24 months (does not count towards OOP Max)	20%*
MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE		
Inpatient Facility	$600/admit, then 10%*	20%*
Inpatient Physician	No charge	20%*
Outpatient Visits (physician)	$35 copay	20%*
Prescription Drug Coverage	**Medimpact Mandatory Generic Retail[1]**	
Deductible (Individual/Family)	None	
Out-of-Pocket Max (Individual/Family)	$2,500 / $5,000	$2,500 / $5,000
RETAIL RX (UP TO 30-DAY SUPPLY)		
Generic	$15 copay	
Formulary Brand	$45 copay	
Non-Formulary Brand[2]	$60 copay	
MAIL ORDER RX (90-DAY SUPPLY)		
Generic	$30 copay	
Formulary Brand	$90 copay	
Non-Formulary Brand[2]	$120 copay	
Specialty (30-day supply)	25% ($150 max.)	

Medical Benefits Standard PPO

The Standard PPO plan offers freedom of choice and allows you the ability to go out-of-network. You may obtain services from any provider you choose, but your costs will be lower when utilizing the UConn Health Community System National Network (Tier 1) or the Anthem BlueCross BlueShield Network (Tier 2) Provider. Your out-of-pocket costs will be lowest when care is received within the UConn Health Community System National Network. For services received Out-of-Network, you will be responsible for any difference between the covered expense and actual charges.

	Anthem BlueCross BlueShield Standard PPO		
	Tier 1 UConn Health Community System National Network**	**Tier 2 Anthem BlueCross BlueShield Preferred Network**	**Tier 3 Out-of-Network*****
LIFETIME PLAN MAXIMUM (PER INDIVIDUAL)			
Essential Health Benefits	Unlimited		
CALENDAR YEAR DEDUCTIBLE			
Individual	$0	$1,630	$5,080
Family	$0	$4,890	$15,240
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)			
Individual	$2,750	$5,000	$8,650
Family	$8,250	$10,000	$25,950
PHYSICIAN SERVICES			
Office Visit (Primary Care Physician)	$35 copay	20%*	40%*
Office Visit (Specialist)	$40 copay	20%*	40%*
Surgeon, Assistant Surgeon, Anesthesia	No charge	20%*	40%*
Teladoc (Telemedicine Visit)	$10 copay		
INPATIENT SERVICES - FACILITY			
Inpatient Hospital Room & Board	$600/admit, then 10%	20%*	40%*
OUTPATIENT SERVICES - FACILITY			
Outpatient Lab, X-Ray, Diagnostic	No charge	20%*	40%*
Outpatient Surgery	$300/service, then 10%	20%*	40%*
Ambulatory Surgical Center	$300/admit, then 10%	20%*	40%*
Hospital-Outpatient Treatment (nonsurgical & other expenses)	No charge	20%*	40%*
EMERGENCY CARE			
Urgent Care	$35 copay		40%*
Emergency Room (copay waived if admitted)	No charge	20%*	
Emergency Room Physician	No charge	No charge	No charge
Ambulance	10%	10%*	10%*
PREVENTIVE CARE / WELLNESS SERVICES			
Physical Exams and Periodic Check-Ups	No charge	No charge	40%*
Well Baby and Well Child Care	No charge	No charge	40%*
Well Woman Exams	No charge	No charge	40%*
Immunizations	No charge	No charge	40%*

* After deductible

** When service is available and based on covered benefits where you are employed.

*** When utilizing Out-of-Network benefits, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the provider / facility any difference between the Plan's payment and the provider's / facility's full charge for the services.

Medical Benefits Standard PPO (Continued)

	Anthem BlueCross BlueShield Standard PPO		
	Tier 1 UConn Health Community System National Network**	**Tier 2 Anthem BlueCross BlueShield Preferred Network**	**Tier 3 Out-of-Network*****
OTHER PROVIDER SERVICES			
Physical, Speech & Occupational Therapy (60 combined visits/cal yr)	$40 copay	20%*	40%*
Chiropractic Care	Not covered	Not covered	Not covered
Acupuncture	Not covered	Not covered	Not covered
Allergy Services - Primary Care	$35 copay	20%*	40%*
Allergy Services - Specialist	$40 copay	20%*	40%*
Allergy Services - Injections & Serum	No charge	20%*	40%*
PREGNANCY AND MATERNITY CARE			
Pre-Natal Care (Initial Visit)	No charge	No charge	40%*
Inpatient Hospital Room and Semi Private	$600/admit, then 10%	20%*	40%*
GENERAL MEDICAL SERVICES			
Physician's Office, Lab and X-Ray	No charge after OV copay	20%*	40%*
Independent Lab and X-Ray	No charge	20%*	40%*
Advanced Imaging	No charge	20%*	40%*
Skilled Nursing or Extended Care Facility (up to 100 visits/cal year)	No charge	20%*	40%*
Home Health Care (up to 100 visits/cal year)	$35 copay	20%*	40%*
Hospice Care			
Durable Medical Equipment	No charge	20%*	40%*
Hearing Aid Services & Ancillary Equipment	No charge	20%*	40%*
Hearing Aid Services & Ancillary Equipment	No charge	20%	40%
	$2,000 allowance every 24 months (does not count towards OOP Max)		
MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE			
Inpatient Facility	$600/admit, then 10%	20%*	40%*
Inpatient Physician	No charge	20%*	40%*
Outpatient Visits (physician)	$35 copay	20%*	40%*
Prescription Drug Coverage	**Medimpact Mandatory Generic Retail[1]**		**Tier 3**
Deductible (Individual/Family)	None		None
Out-of-Pocket Max (Individual/Family)	$2,500 / $5,000		N/A
RETAIL RX (UP TO 30-DAY SUPPLY)			
Generic	$15 copay		Not covered
Formulary Brand	$45 copay		
Non-Formulary Brand[2]	$60 copay		
MAIL ORDER RX (90-DAY SUPPLY)			
Generic	$30 copay		Not covered
Formulary Brand	$90 copay		
Non-Formulary Brand[2]	$120 copay		
Specialty (30-day supply)	25% ($150 max.)		

Medical Benefits Premier PPO

The Premier PPO plan offers the ultimate freedom of choice and is the richest plan offered. You may obtain services from any provider you choose, but your costs will be lower when utilizing the UConn Health Community System National Network (Tier 1) or the Anthem BlueCross BlueShield Network (Tier 2) Provider. For services received Out-of-Network, you will be responsible for any difference between the covered expense and actual charges.

	Anthem BlueCross BlueShield Premier PPO		
	Tier 1 UConn Health Community System National Network**	**Tier 2 Anthem BlueCross BlueShield Preferred Network**	**Tier 3 Out-of-Network*****
LIFETIME PLAN MAXIMUM (PER INDIVIDUAL)			
Essential Health Benefits		Unlimited	
CALENDAR YEAR DEDUCTIBLE			
Individual	$0	$500	$500
Family	$0	$1,500	$1,500
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)			
Individual	$2,250	$2,650	$4,650
Family	$5,625	$6,625	$13,950
PHYSICIAN SERVICES			
Office Visit (Primary Care Physician)	$20 copay	$30 copay	30%*
Office Visit (Specialist)	$25 copay	$30 copay	30%*
Surgeon, Assistant Surgeon, Anesthesia	No charge	10%*	30%*
Teladoc (Telemedicine Visit)		$10 copay	
INPATIENT SERVICES - FACILITY			
Inpatient Hospital Room & Board	No charge	10%*	30%*
OUTPATIENT SERVICES - FACILITY			
Outpatient Lab, X-Ray, Diagnostic	No charge	10%*	30%*
Outpatient Surgery	No charge	10%*	30%*
Ambulatory Surgical Center	No charge	10%*	30%*
Hospital-Outpatient Treatment (nonsurgical & other expenses)	No charge	10%*	30%*
EMERGENCY CARE			
Urgent Care	$25 copay	$30 copay	30%*
Emergency Room (copay waived if admitted)	No charge	$120 + 10%*	
Emergency Room Physician	No charge	No charge	No charge
Ambulance	10%	10%*	10%*
PREVENTIVE CARE / WELLNESS SERVICES			
Physical Exams and Periodic Check-Ups	No charge	No charge	Not covered
Well Baby and Well Child Care	No charge	No charge	Not covered
Well Woman Exams	No charge	No charge	Not covered
Immunizations	No charge	No charge	Not covered

* After deductible

** When service is available and based on covered benefits where you are employed.

*** When utilizing Out-of-Network benefits, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the provider / facility any difference between the Plan's payment and the provider's / facility's full charge for the services.

Medical Benefits Premier PPO (Continued)

	Anthem BlueCross BlueShield Premier PPO		
	Tier 1 UConn Health Community System National Network**	**Tier 2 Anthem BlueCross BlueShield Preferred Network**	**Tier 3 Out-of-Network*****
OTHER PROVIDER SERVICES			
Physical, Speech & Occupational Therapy (60 combined visits/cal yr)	$25 copay	$30 copay	30%*
Chiropractic Care	$30 copay, 12 visits maximum per year	$30 copay, 12 visits maximum per year	Not covered
Acupuncture	$30 copay	$30 copay	$30 copay
Allergy Services - Primary Care	$25 copay	$30 copay	30%*
Allergy Services - Specialist	$25 copay	$30 copay	30%*
Allergy Services - Injections & Serum	$25 copay	$30 copay	30%*
PREGNANCY AND MATERNITY CARE			
Pre-Natal Care (Initial Visit)	No charge	No charge	No charge
Inpatient Hospital Room and Semi Private	No charge	10%*	30%*
GENERAL MEDICAL SERVICES			
Physician's Office, Lab and X-Ray	No charge after OV copay	No charge after OV copay	30%*
Independent Lab and X-Ray	No charge	$40 copay*	30%*
Advanced Imaging	No charge	$40 copay*	30%*
Skilled Nursing or Extended Care Facility (up to 100 visits/cal year)	No charge	10%*	30%*
Home Health Care (up to 100 visits/cal year)	10%	10%*	Not covered
Hospice Care	No charge	10%*	Not covered
Durable Medical Equipment	10%	10%*	30%
Hearing Aid Services & Ancillary Equipment	10%	10%	30%
	$2,000 allowance every 24 months (does not count towards OOP Max)		
MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE			
Inpatient Facility	No charge	10%*	30%*
Inpatient Physician	No charge	10%*	30%*
Outpatient Visits (physician)	$25 copay	$30 copay	30%*
Prescription Drug Coverage	**Medimpact Mandatory Generic Retail[1]**		**Tier 3**
Deductible (Individual/Family)	None		None
Out-of-Pocket Max (Individual/Family)	$2,500 / $5,000		N/A
RETAIL RX (UP TO 30-DAY SUPPLY)			
Generic	$15 copay		Not covered
Formulary Brand	$45 copay		
Non-Formulary Brand[2]	$60 copay		
MAIL ORDER RX (90-DAY SUPPLY)			
Generic	$30 copay		Not covered
Formulary Brand	$90 copay		
Non-Formulary Brand[2]	$120 copay		
Specialty (30-day supply)	25% ($150 max.)		

Medical Benefits Value PPO

The Value PPO offers freedom of choice and allows you the ability to go out-of-network. You may obtain services from any provider you choose, but your costs will be lower when utilizing the UConn Health Community System National Network (Tier 1) or the Anthem BlueCross BlueShield Network (Tier 2) Provider. This PPO has high deductibles and cost sharing but your annual preventive exams are always covered at 100% within the Tier 1 or Tier 2 networks. For services received Out-of-Network, you will be responsible for any difference between the covered expense and actual charges.

	Anthem BlueCross BlueShield Value PPO		
	Tier 1 UConn Health Community System National Network**	**Tier 2 Anthem BlueCross BlueShield Preferred Network**	**Tier 3 Out-of-Network*****
LIFETIME PLAN MAXIMUM (PER INDIVIDUAL)			
CALENDAR YEAR DEDUCTIBLE			
Individual	$3,000	$5,900	$10,000
Family	$6,000	$11,800	$20,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)			
Individual	$5,000	$5,900	$30,000
Family	$10,000	$11,800	$60,000
PHYSICIAN SERVICES			
Office Visit (Primary Care Physician)	No charge*		50%*
Office Visit (Specialist)	No charge*		50%*
Surgeon, Assistant Surgeon, Anesthesia	No charge*		50%*
Teladoc (Telemedicine Visit)	$10 copay		
INPATIENT SERVICES - FACILITY			
Inpatient Hospital Room & Board	No charge*		50%*
OUTPATIENT SERVICES - FACILITY			
Outpatient Lab, X-Ray, Diagnostic	No charge*		50%*
Outpatient Surgery	No charge*		50%*
Ambulatory Surgical Center	No charge*		50%*
Hospital-Outpatient Treatment (nonsurgical & other expenses)	No charge*		50%*
EMERGENCY CARE			
Urgent Care	No charge*		10%*
Emergency Room (copay waived if admitted)	No charge*		No charge*
Emergency Room Physician	No charge*		10%*
Ambulance	No charge*		10%*
PREVENTIVE CARE / WELLNESS SERVICES			
Physical Exams and Periodic Check-Ups	No charge		50%*
Well Baby and Well Child Care	No charge		50%*
Well Woman Exams	No charge		50%*
Immunizations	No charge		50%*

* After deductible

** When service is available and based on covered benefits where you are employed.

*** When utilizing Out-of-Network benefits, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the provider / facility any difference between the Plan's payment and the provider's / facility's full charge for the services.

Medical Benefits Value PPO (Continued)

	Anthem BlueCross BlueShield Value PPO		
	Tier 1 UConn Health Community System National Network**	**Tier 2 Anthem BlueCross BlueShield Preferred Network**	**Tier 3 Out-of-Network*****
OTHER PROVIDER SERVICES			
Physical, Speech & Occupational Therapy (60 combined visits/cal yr)	No charge*	No charge*	50%*
Chiropractic Care		Not covered	
Acupuncture		Not covered	
Allergy Services - Primary Care	No charge*	No charge*	50%*
Allergy Services - Specialist	No charge*	No charge*	50%*
Allergy Services - Injections & Serum	No charge*	No charge*	50%*
PREGNANCY AND MATERNITY CARE			
Pre-Natal Care (Initial Visit)	No charge	No charge	No charge
Inpatient Hospital Room and Semi Private	No charge*	No charge*	No charge*
GENERAL MEDICAL SERVICES			
Physician's Office, Lab and X-Ray	No charge*		50%*
Independent Lab and X-Ray	No charge*		50%*
Advanced Imaging	No charge*		50%*
Skilled Nursing or Extended Care Facility (up to 100 visits/cal year)	No charge*		50%*
Home Health Care (up to 100 visits/cal year)	No charge*		50%*
Hospice Care	No charge*		50%*
Durable Medical Equipment	No charge*		50%*
Hearing Aid Services & Ancillary Equipment	20%		50%
	$2,000 allowance every 24 months (does not count towards OOP Max)		
MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE			
Inpatient Facility	No charge*		50%*
Inpatient Physician	No charge*		50%*
Outpatient Visits (physician)	No charge*		50%*
Prescription Drug Coverage	**Medimpact Mandatory Generic Retail[1]**		**Tier 3**
Deductible (Individual/Family)	None		None
Out-of-Pocket Max (Individual/Family)	$2,650 / $5,300		N/A
RETAIL RX (UP TO 30-DAY SUPPLY)			
Generic	$15 copay		Not covered
Formulary Brand	$45 copay		
Non-Formulary Brand[2]	$60 copay		
MAIL ORDER RX (90-DAY SUPPLY)			
Generic	$30 copay		Not covered
Formulary Brand	$90 copay		
Non-Formulary Brand[2]	$120 copay		
Specialty (30-day supply)	25% ($150 max.)		

Prescription Drugs

Administered by MedImpact

Your medical plan includes coverage for prescription medication. When you enroll in the EPO or PPO medical plans, you are automatically enrolled in the prescription drug plan administered by Medimpact. The prescription drug information is combined with your medical ID card. To access a complete listing of Medimpact pharmacies near you, log onto **www.medimpact.com**.

Exclusive Home Delivery for Maintenance Medications

If you take maintenance medication, such as those used to treat high blood pressure or high cholesterol, you can avoid higher costs by taking advantage of the convenience of home delivery pharmacy services. This program allows you to refill maintenance medications at a retail pharmacy twice without incurring a higher cost. After the second purchase, you'll be responsible for paying the entire cost of the medication when using a retail pharmacy. You can avoid these higher costs by signing up for home delivery by contacting Medimpact at **877.403.6040** or log in to **www.medimpact.com**.

MedImpact Direct Specialty Program

The MedImpact Direct Specialty Program provides access to specialty drugs for chronic and complex conditions. Whether the medication is new for you, or if you have been taking it for a while, the dispensing pharmacy will help you get the most from your medication.

MedImpact Direct Specialty is here to help. Call **877.391.1103** (available Monday through Friday from 8 am to 8 pm Eastern Time). Or email at **specialtyservicecenter@medimpactdirect.com**.

Telemedicine

Virtual Care, or telemedicine, is a great alternative to urgent care and emergency room visits because it provides you 24/7/365 access to U.S. board-certified doctors – receive the treatment you need in an easy and timely manner. In addition, you have the ability to send your visit results to your primary care physician.

Telemedicine offers you:

- 24/7/365 convenience
- No Emergency Room Waits
- Quality Doctors

Call **800.835.2362**
Visit **TeladocHealth.com**
Download the app

Remote Health Care Can Treat Many Common Health Issues

Through virtual care, doctors can diagnose many health issues like cold and flu symptoms, allergies, rash, skin problems and so much more! If medically necessary, a prescription will be sent to the pharmacy of your choice.

- Abdominal Pain/Cramps
- Animal/Insect Bites
- Backache
- Cold and Flu Symptoms
- Eye Infection/Irritation
- Laryngitis
- Respiratory infection
- Sore Throat
- Strep
- Allergies
- Asthma
- Blood Pressure Issues
- Dizziness
- Headaches/Migraines
- Poison Ivy/Oak
- Sinusitis
- Sprains and Strains
- Bronchitis

Refer to the Medical plans in this Guide for copayment information.

Medical Expense Reimbursement Plan (MERP)

The Medical Expense Reimbursement Plan reimburses you (the employee) and your dependents for eligible health care expenses incurred under alternate group health coverage.

Who is Eligible?

This plan is voluntary and available to all benefit eligible employees and their eligible dependent child(ren) who are currently enrolled in the UCHCN Medical Plan and who enroll in a qualified, alternate group Medical Plan for 2026.

New hires and those who become newly eligible for medical benefits are not eligible to enroll in MERP in 2026. You may be eligible in 2027 if you meet the above eligibility requirements.

MERP Benefits

- Copays, deductibles and coinsurance reimbursed by the MERP up to $10,600/single and $21,200/family per year.
- This is no cost to you; there is no premium contribution deducted from your paycheck.

How Does the MERP work?

- Waive coverage for yourself and eligible dependent child(ren) under the UCHCN Medical Plan.
- Enroll yourself and/or dependent child(ren) into a qualified alternate plan, typically your spouse's plan.
- Enroll in the MERP plan using Oracle.
- You will receive a MERP ID card. Present your MERP ID card at the time of service, after the ID card for your alternate plan. The MERP ID card will give the provider information for filing claims for co-pays, co-insurance and deductibles.

IRS Rules

- You may be enrolled in an HRA or FSA. You CANNOT be reimbursed from both the MERP and your HRA or FSA.
- **You are NOT eligible for the MERP if your alternate coverage is:**
- A high deductible health plan (HDHP) with active contributions to a Health Savings Account (HSA);
- Medicare, Medicaid, Tricare (Retiree only);
- An Individual Policy.

The MERP is administered by Catilize Health, who has a dedicated staff to personally handle your claims.

Any paper claims can be submitted by fax, email or by U.S. mail. Claim forms are available from Catilize Health.

If you have questions regarding claims or benefits, please call Catilize Health at **877.872.4232**, fax **877.599.3724** or email: **info@catilizehealth.com**.

Dental Benefits

Administered by Delta Dental PPO

Your dental options promote and encourage preventive dental care and provide benefits for services that are essential to good oral health.

Delta Dental PPO offers a network of dentists who have agreed to reduced contracted rates for their services and they cannot "balance bill" enrollees for additional charges. You are able to visit any licensed dentist of your choice, but you will usually have less out-of-pocket expenses when you visit a Delta Dental PPO network dentist. A Delta Dental Premier® dentist is your next best bet; their contracted rates are slightly higher than those of PPO dentists, but you will still enjoy some cost protection.

Enrollees who visit Delta Dental dentists receive the advantages of no billing beyond the charges allowed by the plan and the submission of claims by dentists.

Dental Plan Overview

	Delta Dental PPO*	
	Delta Dental PPO Dentists**	**Non-Delta Dental PPO Dentists****
CALENDAR YEAR DEDUCTIBLE		
Individual	$25	$50
Family	$75	$150
CALENDAR YEAR PLAN MAXIMUM		
Per Individual	$2,000	$1,500
	You Pay	**You Pay**
PREVENTIVE CARE		
Oral Exams, X-rays, Cleanings, Fluoride, Space Maintainers	No charge (deductible waived)	20% (deductible waived)
BASIC SERVICES		
Oral Surgery, Fillings, Endodontic Treatment, Periodontic Treatment, Repairs of Dentures and Crowns, Sealants	20%	20%
MAJOR SERVICES		
Crowns, Jackets, Dentures, Bridge Implants	50%	50%
ORTHODONTIA		
Covered (Adult & Child to age 26)	50%	
Lifetime Orthodontia Plan Maximum (Per Individual)	$1,500	

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

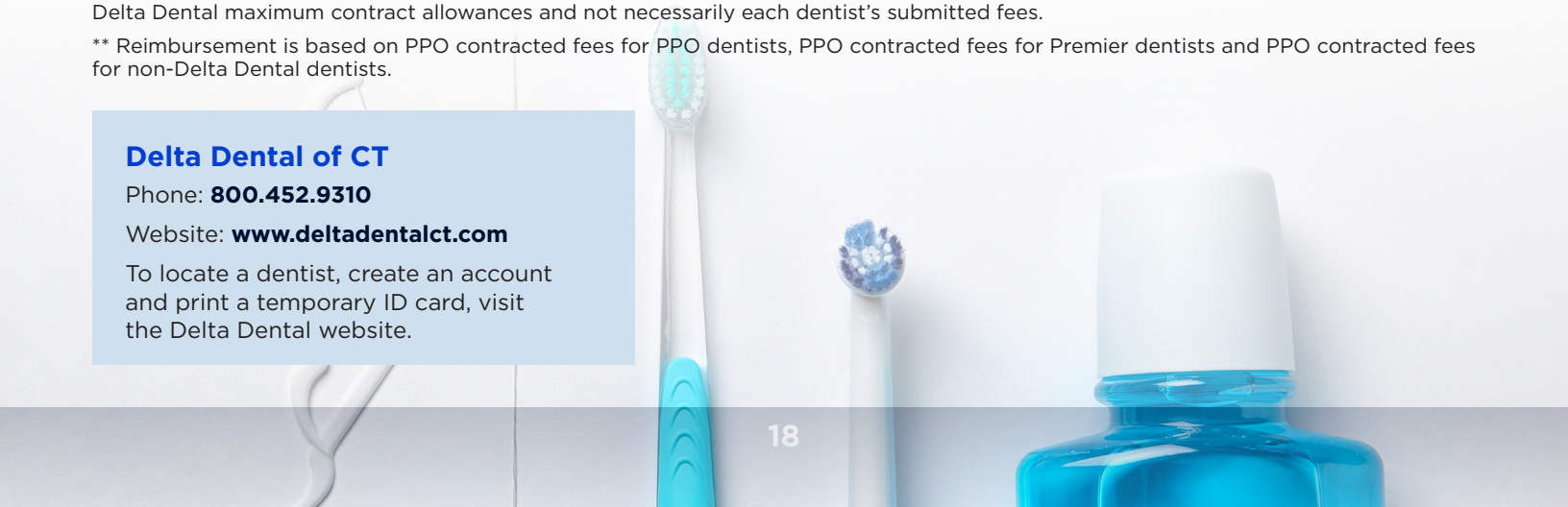
** Reimbursement is based on PPO contracted fees for PPO dentists, PPO contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists.

Delta Dental of CT

Phone: **800.452.9310**

Website: **www.deltadentalct.com**

To locate a dentist, create an account and print a temporary ID card, visit the Delta Dental website.



Vision Insurance

Administered by VSP

Vision care is essential to your overall health. Getting regular eye exams helps your doctor detect a variety of medical conditions before they become big problems.

Your vision plan is administered by Vision Service Plan (VSP), one of America's oldest and largest eye care organizations. VSP offers a network of thousands of eye care professionals located throughout the country. You may use any provider, but you will receive greater benefits when you select a VSP Choice Network Preferred Provider. To use your VSP plan, just call a VSP provider and make an appointment and identify yourself as a VSP member. There are no claim forms to file when you use a VSP provider; you simply pay any amounts not covered by the plan. To use other providers, you will need to pay in full for the services, and then file a claim with VSP.

	VSP Vision Plan	
	In-Network You pay	**Out-of-Network Reimbursement**
EXAM & MATERIALS		
Exam	$15 copay	Up to $45 reimbursement after $15 copay
Materials	$20 copay	Eye wear reimbursement listed below after $20 copay
LENSES		
Single	100% after copay	Up to $45 reimbursement
Bifocals	100% after copay	Up to $65 reimbursement
Trifocals	100% after copay	Up to $85 reimbursement
FRAMES*		
Frames	$250 allowance after copay	Up to $47 reimbursement
CONTACT LENSES (IN LIEU OF LENSES & FRAMES)**		
Medically Necessary	100% after copay	Up to $210 reimbursement
Elective	$200 allowance; copay waived	Up to $150 reimbursement (lenses / exam combined)
BENEFIT FREQUENCY		
Exams	Once every calendar year	Once every calendar year
Lenses	Once every calendar year	Once every calendar year
Frames	Once every two calendar years	Once every two calendar years
Contacts	Once every calendar year	Once every calendar year

* You may use your frame allowance toward ready-to-wear non-prescription sunglasses from a VSP doctor.

** Contacts (every calendar year) in lieu of lenses and frames. $60 allowance for contact lens exam (fitting and evaluation); members also receive 15% discount on contact lens exam and services.

Vision Service Plan

Phone: **800.877.7195**

Website: **www.vsp.com**

To locate a VSP provider or print an ID card, log on to the VSP website.

Life and AD&D Insurance

Insured by UConn Health Community Network

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

UConn Health Community Network provides Basic Term Life to eligible employees. Accidental Death & Dismemberment (AD&D) insurance is an additional benefit offered to employees meeting the eligibility requirements.

- Coverage is provided to full-time and part-time employees by The Standard at no cost to you, paid for by UConn Health Community Network.
- CHCA Nurses: For basic life insurance, you are covered in an amount equal to 1.5x annual earnings, up to $100,000.
- CHCA Techs: For basic life insurance, you are covered in an amount equal to 1x annual earnings, up to $100,000.
- Non-Union Employees: For basic life and AD&D insurance, you are covered in an amount equal to 1x annual earnings, up to $100,000.
- AD&D insurance pays specific benefit amounts for a covered accidental bodily injury that causes dismemberment. If death occurs from an accident, 100% of the AD&D benefit would be payable to your beneficiary.
- Benefits are paid to the beneficiary you designate. Please keep your beneficiary information up to date.

Things to Keep in Mind

Life and AD&D insurance provides many benefits, but there are a few points to keep in mind:

- **Imputed Income:** The value of your company-provided life insurance premiums over $50,000 is considered taxable. Contact your tax professional for more information.
- **Age Reduction:** Benefit amounts reduce as you age. At age 70, reduction to 65% of the benefit amount. At age 75, reduction to 50% of the benefit amount.
- **Portability:** If you leave the company, you may be able to convert your policy to an individual policy and continue your coverage.

Additional Information

- Annually, during the Open Enrollment period, you may increase your Optional Life election one level without the Evidence of Insurability requirement up to the Guaranteed Issue amount.
- To learn more, please see the schedule of benefits for a full list of benefits and costs.

Optional Life Insurance

- As a full-time or part-time employee, you may purchase Optional Life insurance for yourself and your dependents for additional financial protection through The Standard. Premiums are determined by your age and will be deducted from your paycheck after tax. You may elect spouse and/or dependent life insurance for your eligible dependent children if you elect Optional Life for yourself. You may not be covered as an employee and as a dependent.
- For any Optional Life amount elected after your initial eligibility period or above the Guarantee Issue amount, you must complete a medical questionnaire (Evidence of Insurability) and be approved for the amount elected. Your coverage will be effective the first of the month following approval. You do not have to purchase the same amount for Optional Life and Optional AD&D.

Coverage	Available benefit
Employee	▪ Increments of $10,000, up to a maximum of $300,000 ▪ Guaranteed issue amount: $100,000
Spouse	▪ Increments of $5,000 to a max of $105,000 ▪ Guaranteed issue amount: $30,000
Dependent Child(ren) live birth to 6 months	▪ $500 ▪ Guaranteed issue amount: $500
Dependent Child(ren) 6 months to age 26	▪ $10,000 ▪ Guaranteed issue amount: $10,000

Guaranteed Issue

Guarantee Issue is the amount of insurance you are guaranteed without having to complete Evidence of Insurability (EOI). Any amounts above the Guaranteed Issue amount are subject to underwriting where you will be required to complete an EOI form.

Disability Insurance

Insured by UConn Health Community Network

The Standard
Phone: **800.422.1549**
Website: **www.standard.com**

An unexpected injury or illness can create a financial burden. Disability insurance replaces a portion on your income when you are unable to work.

Important: Disability benefits are reduced by other income you receive, such as Social Security, state disability benefits, pension benefits, and Workers' Compensation.

Optional Short Term Disability

Short Term Disability (STD) is an optional program provided by The Standard and is offered to full-time and part-time benefit eligible employees. STD insurance provides a portion of your weekly income for a non-work-related short-term injury or illness. You may purchase Short Term Disability coverage with after-tax dollars.

Plan Benefits	Short Term Disability
Eligible Class	Eligible Employees
Weekly Benefit	60% of weekly earnings
Weekly Maximum	$2,000
Elimination Period	14 days accident / sickness
Benefit Duration	26 weeks
Funding	Voluntary

Helpful Disability Insurance Terms

Qualifying disability: A sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training, or experience.

Benefit Duration: Maximum amount of time you may receive proceeds for a continuous disability.

Elimination or Waiting Period: The time you must wait before you are eligible to receive benefit payments.

Additional Information

You will be subject to pre-existing limitations under the STD and LTD plans if you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and the disability begins in the first 12 months after your effective date of coverage.

To learn more, please see the schedule of benefits for a full list of benefits and costs.

Long Term Disability

When your STD benefits end and you are still injured or ill and unable to work, LTD insurance takes over to help pay for ongoing living expenses such as rent, mortgage, car payments, utilities or out-of-pocket medical expenses. You will receive a portion of your monthly income for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever comes first. LTD is provided by UConn Health Community Network for full-time employees at no cost to you. You have the opportunity to increase your benefit by purchasing additional voluntary coverage.

Plan Benefits	Non-Union
Eligible Class	Eligible Employees
CORE BENEFIT (EMPLOYER PAID)	
Monthly Benefit	60% of monthly earnings
Monthly Maximum	$2,000
BUY-UP BENEFIT (EMPLOYEE PAID)	
Monthly Benefit	60% of monthly earnings
Monthly Maximum	$10,000
Offset by Other Disability Benefits?	Yes*
Elimination Period	180 days
Benefit Duration	To Social Security normal retirement age (see policy for benefit amounts beyond SSNRA)

Plan Benefits	Union
Eligible Class	Eligible Employees
CORE BENEFIT (EMPLOYER PAID)	
Monthly Benefit	N/A
BUY-UP BENEFIT (EMPLOYEE PAID)	
CHCA Nurses/CHCA Tech	
Monthly Benefit	60% of monthly earnings
Monthly Maximum	$6,000
1199	
Monthly Benefit	50% of monthly earnings
Monthly Maximum	$2,500
Offset by Other Disability Benefits?	Yes*
Elimination Period	180 days
Benefit Duration	To ADEA (see policy for benefit amounts)

*Refer to the contract for details.

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax funds to pay for health care and dependent care expenses. Since these contributions are not subject to federal, state or payroll tax withholding, you keep more of your paycheck.

- If you are not making any changes to your current benefit elections but would like to participate in the Health Care and/or Dependent Care FSAs in 2026, you must enroll annually via Oracle.
- Your contributions will be deducted from your paychecks in equal installments throughout the year and deposited into your account(s). This process is called pre-taxing. By pre-taxing, you lower your gross taxable income. As a result, you pay fewer taxes and keep more of what you earn.
- You cannot change your contribution amount during the year unless you have a qualifying event.
- Flexible Spending Accounts are based on the IRS "Use It or Lose It" rule. Estimate your contribution amounts carefully, as unused funds will be forfeited after the end of the closing date.
- Keep your receipts. The FSA Administrator or IRS may request them at any time.
- Keep in mind that you cannot transfer from one FSA to another.
- **For your convenience, you will receive a Health Care Debit Card from Navia.**

Health Care FSA

The Health Care FSA can be used to pay out-of-pocket medical, dental, vision and prescription drug expenses not covered by insurance plans with pre-tax dollars.

- **Annual Contribution Limit:** $3,400
- **Eligible Expenses:** Copays, coinsurance, deductibles, prescription expenses (For a full list, visit **www.irs.gov** Publication 502)
- **Funds Available:** Full amount is available at the beginning of the plan year
- **Payment or Reimbursement Options:** FSA Debit Card, Direct Deposit, Check
- **Deadline for Services:** December 31, 2026
- **Deadline to Submit Claims for Reimbursement:** April 15, 2027

You must re-enroll in the Health Care FSA in order to use any unspent 2025 HCFSA funds up to $640 through the end of the 2026 plan year.

Dependent Care FSA

The Dependent Care FSA can be used to pay eligible day care expenses for your children under age 13 or a dependent adult to allow you or your spouse to work or attend school full time.

- **Annual Contribution Limit:** $7,500 ($3,750 if married and filing separate tax returns)
- **Eligible Expenses:** Day care, after-school care, babysitting (work-related), nanny (For a full list, visit **www.irs.gov** Publication 503)
- **Funds Available:** You may only use up to the amount of funds you have in your account
- **Payment or Reimbursement Options:** Direct Deposit or Check
- **Deadline for Services:** December 31, 2026
- **Deadline to Submit Claims for Reimbursement:** April 15, 2027

Travel Assistance

Insured by The Standard

Unforeseen events or circumstances can unravel travel plans. Medical problems or a lost passport can happen at inconvenient times. Travel Assistance through The Standard can help you navigate these issues and more at any time through Assist America, Inc.

Call: **800.936.1405**

Email: **info@transitionsrbg.com** | **www.transitionsrbg.com**

Emergency Travel Assistance

Travel Assistance is available while you are more than 100 miles away from home or internationally for up to 180 days for business or personal travel. With one simple phone call, you can be connected to Assist America's staff of medically trained, multilingual professionals who can advise you 24/7.

You have immediate access to:

- Hospital admission assistance
- Emergency trauma counseling
- Care and transport of unattended minor children
- Emergency medical evacuation
- Prescription replacement assistance
- Legal and interpreter services
- Passport replacement assistance

Within the U.S.: **800.872.1414**
Outside the U.S.: **609.986.1234**
Text: **609.334.0807**

Email: **medservices@assistamerica.com**
Reference number: 01-AA-STD-5201

UConn Health Community Network 401(k) Plan

UCHCN offers a 401(k) plan as a valuable tool for you to save for retirement.

All employees who are employed by UCHCN on the date of plan start-up, March 15, 2026, will be immediately eligible for the plan.

- You will be able to enroll in the Plan prior to March 15th at **Principal.com/Welcome**. As soon as the enrollment option becomes available you will be notified. You can use your current Principal username and password to access your new UCHCN 401(k) Plan account.
- If you do not enroll in the plan, you will be automatically enrolled at a Pre-tax contribution rate of 4%. If you are automatically enrolled, your contributions will automatically be increased by 1% each year, up to a maximum of 10%.
- You can enroll in the plan or change your contribution rate at any time.

When you enroll in the plan, you can make your contributions as either Pre-tax or Roth, or a combination of the two methods.

- The contribution limit for 2026 is $24,500. Please keep in mind that this is the total limit for all retirement plans, not just the UCHCN 401(k) Plan.
- If you are 50 or over by December 31, 2026, you are eligible to make a catch-up contribution up to $8,000 for 2026. If you turn age 60-63 during 2026, you can make an additional catch-up contribution of $3,250 for 2026.
- Beginning after the transaction to UCHCN, you may be eligible for the new safe harbor match contribution. Please refer to the Summary Plan Description (SPD) for full details regarding eligibility and matching provisions. If you are eligible, UCHCN will match your contributions 100% of the first 3% contributed plus 50% of deferrals between 3% and 5%. You are immediately 100% vested in the new matching contribution.

You are able to roll over your balance from the PMH Plan.

- Communications that you may have received from Principal communicated a March 23, 2026, deadline date to allow for rollover processing; however, as long as you request a rollover by April 2, 2026, it will be processed and rolled to the UCHCN 401(k) Plan.

There are a variety of mutual fund investment options, including target date funds, available in the Plan.

- You can access information about the funds and choose how you would like your contributions invested via the Principal website.
- You can transfer your balances between funds or change how your contributions are invested at any time.

Account Management

- You can view your account with Principal at any time using their app, at **www.principal.com** or by calling the Participant Service Center at **800.657.7754**.

Additional Benefits

Voluntary Identity Theft Insurance

LifeLock with Norton Benefit Premier Plus focuses on what matters to you—helping protect your identity.

LifeLock scans millions of transactions per second for potential threats to your personal identity. They monitor for new credit application alerts, bank and investment account activity alerts used to obtain unauthorized loans, credit and services in your name. If a threat is detected, it notifies you via email, text, phone or mobile app alerts.

If you become a victim of identity theft while a LifeLock member, you have access to a dedicated U.S.-Based Identity Restoration Specialist to personally manage your case, including coverage for experts and lawyers, if needed.

Important Terms to Know

As you review the information in this benefits guide, you might come across a word that is unfamiliar. Take a look at these terms to better understand your benefits.

Beneficiary:
A person you designate to receive your financial benefits (i.e. life insurance, 401(k), HSA) in the event of your death.

Calendar Year Maximum:
Total amount paid each year by your insurance company for each family member enrolled in the plan.

Claim:
A request for payment that you or your health care provider submits to your health insurer after receiving a service or item.

Coinsurance:
The percentage you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met and can vary based on the plan design.

Copay:
The flat fee you pay toward the cost of covered medical services.

Deductible:
The amount you are responsible for paying for covered health care services before the plan pays benefits. Under some plans, the deductible is waived for certain services.

Dependent:
A dependent would be a legal spouse not eligible for coverage under their employer's health plan. Children up to age 26 including stepchildren, foster children, legally adopted children, and children for whom you are legal guardian and legally responsible to provide health coverage to. Disabled children over the age of 26 where you provide primary support and the disability occurred before the age of 26.

Evidence of Insurability (EOI):
The process in which you provide required health documentation in order to receive certain levels of coverage.

Formulary:
A list of preferred drugs chosen by a panel of doctors and pharmacists. Both brand and generic medications are included on the formulary.

Guaranteed Issue:
The amount of coverage pre-approved by the insurance carrier regardless of health status.

Network:
A designated list of health care providers (doctors, dentists, etc.) with whom the health insurance provider has negotiated special rates. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-Pocket Maximum: The highest amount paid for covered services during a benefit period. Both the deductible and the coinsurance apply towards meeting the out-of-pocket maximum, but copayments may not apply.

Pre-Existing Condition:
A health problem you had before the date that new health coverage starts.

Preauthorization:
A decision by your health plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Preauthorization may be required for certain services before you receive them.

Premium:
The amount you pay for a health plan in exchange for coverage.

Preventive Care:
Routine health care that includes screenings, checkups, and patient counseling to prevent illnesses, disease, or other health problems.

Reasonable and Customary:
The amount of money a health plan determines is the normal or acceptable range of charges for a specific health-related service or procedure.

Vesting:
The point at which benefits become owned by the employee.

Contact Information

Coverage	Carrier/Vendor	Phone	Website
Your Personal Benefits Assistant	Quantum Health	866.920.1994 (Monday-Friday, 5:30am-7:00pm PST)	UCHCNmedical.quantum-health.com
Medical / Prescription Drugs	Quantum Health	866.920.1994 (Monday-Friday, 5:30am-7:00pm PST)	UCHCNmedical.quantum-health.com
Plan ID: PYA	Medimpact Prescription Drugs	877.403.6040	www.medimpact.com
Telemedicine	Teladoc	800-Teladoc	www.teladoc.com/bsc
Medical Expense Reimbursement Plan (MERP)	Catilize Health	Phone: 877.872.4232 Fax: 877.599.3724	Email: info@catilizehealth.com
Wellness	**Wellness program launch date targeted Summer 2026**		
Dental	DeltaCare HMO Delta Dental of Connecticut	800.422.4234 800.452.9310	www.deltadentalins.com www.deltadentalct.com
Vision	Vision Service Plan (VSP)	800.877.7195	www.vsp.com
Life/AD&D & Optional Life/Optional AD&D	The Standard	800.422.1549	www.standard.com
Disability (STD & LTD)	The Standard	800.422.1549	www.standard.com
Flexible Spending Accounts (FSA) and COBRA	Navia	425.452.3500	www.naviabenefits.com
Employee Assistance Program (EAP)	The Standard	800.293.6948	Healthadvocate.com/standard3
Travel Assistance	The Standard	800.872.1414	www.standard.com/travel
401(k) Retirement Plan	Principal	800.547.7754	principal.com
HRconnection	HRconnection	203.573.7644	WTBYHRConnection@wtbyhosp.org
Voluntary Identity Theft	LifeLock	800.607.9174	—

All benefits above can be accessed through Quantum Health, they provide guidance and support for everything.

Legal Notices

Patient Protections Disclosure

The UConn Health Community System, Inc. Health and Welfare Benefit Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Personify Health or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Personify Health at **866.920.1994**.

Women's Health & Cancer Rights Act

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, please note the deductible and coinsurance applicable to your specific plan.

If you would like more information on WHCRA benefits, please call your Plan Administrator at **866.920.1994**.

Newborns' and Mothers' Health Protection Act

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your state for more information on eligibility.

ALABAMA – Medicaid

http://myalhipp.com
855.692.5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
http://myakhipp.com/ | 866.251.4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

http://myarhipp.com
855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
916.445.8322 | Fax: 916.440.5676 | Email: hipp@dhcs.ca.gov

COLORADO – Medicaid and CHIP

Health First Colorado (Colorado's Medicaid Program)
https://www.healthfirstcolorado.com
Member Contact Center: 800.221.3943 | State Relay 711
Child Health Plan Plus (CHP+)
https://hcpf.colorado.gov/child-health-plan-plus
Customer Service: 800.359.1991 | State Relay 711
Health Insurance Buy-In Program (HIBI)
https://www.mycohibi.com/
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid

www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
877.357.3268

GEORGIA – Medicaid

GA HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
678.564.1162, Press 1
GA CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
678.564.1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
https://www.in.gov/medicaid/ | 800.457.4584
Family and Social Services Administration
http://www.in.gov/fssa/dfr/ | 800.403.0864

IOWA – Medicaid and CHIP (Hawki)

Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
800.338.8366
Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
800.257.8563
HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
888.346.9562

KANSAS – Medicaid

https://www.kancare.ks.gov/
800.792.4884 | HIPP Phone: 800.967.4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
855.459.6328 | KIHIPP.PROGRAM@ky.gov
KCHIP: https://kynect.ky.gov | 877.524.4718
Medicaid: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Medicaid: www.ldh.la.gov/healthy-louisiana
Customer Service Line: 888.342.6207
Medicaid Email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP):
https://www.ldh.la.gov/lahipp
LaHIPP Phone: 877.697.6703 | LaHIPP Email: La.HIPP@la.gov
LaHIPP Fax: 888.716.9787
LaHIPP Mailing Address: 100 Crescent Centre Parkway, Suite 1000
Tucker, GA 30084

MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US
800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium:
https://www.maine.gov/dhhs/ofi/applications-forms
800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa
800.862.4840 | TTY: 711 | Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
https://mn.gov/dhs/health-care-coverage/
800.657.3672

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
573.751.2005

MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
800.694.3084 | Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

NEVADA – Medicaid
http://dhcfp.nv.gov
800.992.0900

NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 15218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid
800.356.1561
CHIP: http://www.njfamilycare.org/index.html
800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392

NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/
800.541.2831

NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov
919.855.4100

NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare
844.854.4825

OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org
888.365.3742

OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx
800.699.9075

PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
800.692.7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800.986.KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov
855.697.4347 or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov
888.549.0820

SOUTH DAKOTA – Medicaid
http://dss.sd.gov
888.828.0059

TEXAS – Medicaid
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
800.440.0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
https://medicaid.utah.gov/upp/ | Email: upp@utah.gov | 888.222.2542
Adult Expansion: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/
CHIP: https://chip.utah.gov/

VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program
800.250.8427

VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid and Chip: 800.432.5924

WASHINGTON – Medicaid
https://www.hca.wa.gov/
800.562.3022

WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/
Medicaid: 304.558.1700
CHIP Toll-free: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
800.362.3002

WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
800.251.1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

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Notes

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