

Choice

B E N E F I T S

Applicable to:

**Annually Appointed
Adjunct Faculty**

Enrollment Workbook

What's New?

The following summarizes the changes in Choice Benefits for the 2009 plan year. You can find more detailed information about these changes in the related sections of this workbook.

Annual Enrollment Process Employees will enroll online through Employee Self Service (ESS) at www.ucflex.uc.edu.

Annual Enrollment Deadline The 2009 annual enrollment period begins on October 27, 2008 and ends on December 1, 2008.

Contributions Employee contributions for the HMO have changed. Contribution information can be found online.

Medical Plans Effective January 1, 2009, you will notice that Humana is changing the name of the HMO Network currently offered to UC. The HMO Network will be called HMO Premier.

This change will also make it easier for you to find doctors and hospitals on Physician Finder Plus at Humana.com. Your member ID card will feature the HMO Premier Network name and the plan's effective date.

HMO – You will receive a new ID card if you elect to participate in the HMO.

Spouse or Domestic Partner Surcharge A \$50 monthly Spouse or Domestic Partner surcharge will continue to be assessed. The Surcharge applies to employees who cover a spouse or domestic partner on UC medical insurance and that spouse/domestic partner has the option to elect medical coverage with his/her employer but has opted not to do so.

If you are paying the Surcharge and it will continue to apply, NO ACTION is required unless you are changing your Plan enrollment. See the Enrollment Instructions handout for additional information.

If you are paying the Surcharge and it no longer applies to you effective January 1, 2009, you must update your Surcharge information online. See the Enrollment Instructions handout for additional information.

Coordination of Benefits You will not be required to fill out a form advising of other medical coverage, however, you may be required to provide this information to Humana. You will be contacted directly by Humana.

Qualified Status Changes (QSC) You must notify the Human Resources Service Center (HRSC) within 31 days of a qualified status change (e.g., birth, marriage) in order to make changes to your benefit elections. Once you have notified the HRSC, you will make your enrollment changes online. A paper form will not be accepted.

Flexible Spending Accounts (FSAs) A new provider - CHARD SNYDER - will be our FSA administrator. Participants will be provided with a debit card for use with the Health Care Flexible Spending Account. Watch for additional information.

Accessing Provider Web sites Employees can access the web sites of their medical, prescription and dental plans. Additionally, you can set up a personal account on Humana.com to find providers, view medical, prescription and dental claims history, find information about drugs including side effects, order replacement ID cards, complete an online health risk assessment and much more. Links to websites can be found at www.uc.edu/hr.

Enrollment Workbook on the Internet The Enrollment Workbook can be found online at www.uc.edu/hr.

Table of Contents

Introducing Choice Benefits.....	4
Changing Choices After Enrollment.....	8
Choice Benefits Plan Information	
Medical Coverage.....	9
Flexible Spending Accounts (FSAs).....	13
Tuition Remission.....	16
Leaves and Termination Information	
When Coverages End.....	16
Extending Benefits Through COBRA.....	17
Medicare Prescription Drug Notice.....	18
The Family and Medical Leave Act (FMLA).....	19
How Leaves Affect Coverage.....	21
Health Insurance Portability and Accountability Act (HIPAA).....	21

Introducing Choice Benefits

Choice Benefits enables you to select from various levels of coverage in each benefit area. This workbook describes how the program works and outlines the benefits offered.

Who Is Eligible

You may enroll in Choice Benefits if you are an annually appointed adjunct faculty member.

Your personal information, available online, shows the options for which you are eligible. Your coverage and flexible spending accounts begin on the coverage effective date shown.

If you're on a leave of absence or you will be during 2009, contact the Human Resources Service Center (HRSC) for information about special coverage rules.

You may also enroll eligible dependents in Choice Benefits. *To enroll and maintain benefits coverage for a dependent age 19 or older, you are required to provide proof of eligibility. If a dependent ceases to meet eligibility, you are responsible for notifying the Human Resources Service Center within 31 days of the qualified status change. If a dependent's eligibility cannot be verified or if your response is not timely, that dependent will not be covered for any benefits.* After the plan year begins, the Human Resources Service Center will send out verification requests via mail on an annual basis. Requests will be sent to your home address approximately one week prior to your dependent child's birth month. When proof of eligibility is requested, employees will be required to complete and have the school certify the appropriate section, then return the form to verify the eligibility of their dependents. It may also be necessary to provide the Human Resources Service Center with other documents such as:

Court-Ordered Coverage For Dependents

If you are under a court order to provide benefits for a dependent (such as a court order to provide child support), you must enroll that dependent in coverage.

- ♦ birth certificates,
- ♦ marriage certificate or
- ♦ court orders of legal permanent guardianship or custody.

If the dependent maintains full-time UC student status, you will receive a confirmation letter and a letter requesting IRS dependency verification. If a dependent's eligibility cannot be verified, all benefits for that dependent will be terminated. If coverage is terminated, only one appeal per family for dependent eligibility may be approved, regardless of the number of dependents.

The following chart outlines the eligibility rules for your dependents.

Value & Costs

The university works diligently to offer high quality benefits to you and your family. The university and you share the costs of providing these benefits. The per month employee cost (your cost), employer cost, and plan cost are shown online for each medical option.

If the plan cost of your medical plan is more than the employer cost of the university, you pay the balance through payroll deductions.

Eligible Dependents	Medical
Your husband or wife.	yes
Your domestic partner (see Domestic Partner section)	yes
Your unmarried natural or legally adopted child or stepchild under age 19	yes
Your unmarried child under age 19 for whom you have legal permanent guardianship/ custody from a court of competent jurisdiction. This child must be your IRS dependent and live with you in a regular parent-child relationship.	yes
Your unmarried child from age 19 to age 23 who maintains full-time student status and is your IRS dependent	yes
Your unmarried child under age 19 (or age 19 to 23 if full-time student status is maintained) who is claimed as an IRS dependent by your ex-spouse, if that ex-spouse is also the child's parent.	yes
A child dependent under IRS rules who became disabled by mental retardation or physical handicap before age 19 (medical) or before coverage would normally end (dental). *	yes

Exclusions and Limitations:

* If your child is disabled, you must contact the HRSC **before** his or her 19th birthday to request continued coverage.

Taxes & Choice Benefits

Choice Benefits offers before-tax benefits.

- ♦ medical coverage, and
- ♦ flexible spending accounts.

You do not pay federal, state, city or Medicare taxes on your contributions to purchase these benefits.

Your contributions for these benefits come out of your paycheck **before** taxes are calculated. That is why these contributions are called **before-tax** contributions. These before-tax contributions reduce your taxable income. Because your taxes are figured on a lower amount of income, you pay less tax.

Before-tax contributions offer you valuable tax benefits. Keep in mind that:

- ♦ your before-tax contributions are tax-exempt, not tax-deferred. Taxes will **not** be due later.
- ♦ your before-tax contributions do not affect your other pay-related benefits.

Domestic Partner Coverage

You may cover your domestic partner, opposite or same sex, for medical insurance. To cover a domestic partner the following criteria must be met:

- ♦ You and your domestic partner share a permanent residence (unless residing in different cities, states, or countries on a temporary basis).
- ♦ You and your domestic partner are each other's sole domestic partner, have been in the relationship for at least six months, and intend to remain in the relationship indefinitely.
- ♦ Neither you nor your domestic partner is currently married to or legally separated from another person under either statutory or common law.
- ♦ You and your domestic partner are responsible for each other's common welfare.
- ♦ You and your domestic partner are at least 18 years of age and mentally competent to consent to this contract.
- ♦ You and your domestic partner are not related by blood to a degree of closeness that would prohibit marriage in the state in which you legally reside.
- ♦ You and your domestic partner are financially interdependent on each other in accordance with the plan requirements outlined by the University of Cincinnati. Financial interdependency may be demonstrated by the existence of at least three of the following to verify domestic partnership:
 - Joint ownership of real estate property or joint tenancy on a residential lease
 - Joint ownership of an automobile
 - Joint bank or credit account

Special Rules For Dependent Children Age 19 Or Older

The Human Resources Service Center annually verifies the eligibility of children age 19 or older. You must provide proof that **full-time student status has been maintained** or a physician's statement for disabled children and IRS dependency verification. In order for your child to remain eligible, the child **must maintain full-time student status in each quarter or semester of the normal academic year**. For example, to maintain coverage during the normal summer break, your child must be a full-time student in the term immediately **preceding and following** the summer break (normally June through August). If a dependent's eligibility cannot be verified or if your response is not timely, that dependent will not be covered for any benefits, including tuition remission, **as of the end of the month in which full-time student status was last maintained**.

If coverage is terminated, only **one** appeal per family for dependent eligibility may be approved, regardless of the number of dependents. If you have any questions regarding eligibility requirements for dependents age 19 or older, consult the HRSC.

- Joint liabilities (i.e., credit cards or loans)
- A will designating the domestic partner as the primary beneficiary
- A retirement plan or life insurance policy beneficiary designating the domestic partner as primary beneficiary
- A durable power of attorney signed to the effect that powers are granted to one another

Please note to cover a domestic partner you may be required to complete an Affidavit of Domestic Partnership and agree that you can and will provide the documents to verify domestic partnership. You may download an affidavit from the UC Web site at www.uc.edu/hr.

- ♦ You agree to notify the HRSC in writing and mail a signed copy to your previous domestic partner within 30 days of either of the following events:
 - There is a change in circumstances that would make a domestic partner ineligible for coverage under the terms of the university's plans; or
 - You terminate the domestic partnership.
- ♦ Once a qualified status change in the domestic partnership occurs and the domestic partner is no longer eligible for coverage you may not cover another domestic partner for at least six months.
- ♦ To enroll a domestic partner in coverage you need to select the appropriate level of coverage for yourself, your children, and your domestic partner (i.e., self plus domestic partner, or family plus domestic partner). Please review your enrollment information online.

Taxes and Domestic Partner Coverage

The premium you pay for coverage of a domestic partner for medical insurance is paid on an after-tax basis. The premium for you and your dependent children for medical insurance will remain on a before-tax basis.

The value of the medical insurance for a domestic partner is considered taxable to you under IRS rules for federal, state and local taxes. The value (cost) of a self plan minus the premium for your domestic partner for medical insurance is the amount on which you will be taxed. Refer to your enrollment information for details on the value (cost) for self of the medical plan you choose.

Working Together

The Human Resources Service Center is dedicated to providing you and your family with a competitive program of quality benefits. We think of you as our customer. This means there are certain things you can expect from us.

To do our jobs well, however, we need your help. Just as your doctor can treat you more effectively by knowing your medical history, we serve you better when you keep us informed. This means there are certain things we need from you as our customer.

We ask that you:

- ◆ use your benefits wisely, because the amount you pay for benefits is based on a percentage of their actual costs, so, as UC's costs increase, your costs increase,
- ◆ read the materials we provide to you,
- ◆ notify the Human Resources Service Center when your personal information changes (new address or a change in your family benefits covered by your spouse's employer),
- ◆ contact HRSC when you have questions about your benefits,
- ◆ contact the Human Resources Service Center within 31 days when you want to make a change to your benefits due to a qualified status change,
- ◆ contact the appropriate insurance company with claims questions before contacting the Human Resources Service Center,
- ◆ file appeals with the insurance company within 60 days of receiving notice of a denied claim, and
- ◆ provide accurate, true and complete information to the best of your knowledge, following all guidelines of the plans.

In turn, you have the right to:

- ◆ competitive rates based on UC's buying power to negotiate with health care providers,
- ◆ timely and appropriate customer service delivered with professional courtesy, dignity, sensitivity, and privacy,
- ◆ benefit programs that are fair and responsive to your needs, and
- ◆ file one appeal with the Human Resources Service Center for each type of benefit dispute

Why Enrolling Is Important

Your default benefits depend on whether you are re-enrolling or enrolling for the first time.

If you are re-enrolling, your default benefits will be the same benefits in 2009 that you had in 2008, with this exception:

- ◆ If you are contributing to a flexible spending account, you will not contribute next year. Therefore, your contributions for 2009 will be zero.

If you are enrolling for the first time, you will not be enrolled in medical coverage or the flexible spending accounts.

How To Use This Workbook

This workbook is divided into two major sections:

1. The first section explains your options for enrolling in Choice Benefits and is designed to help you make the best enrollment decisions for you and your family.

If you are re-enrolling and know what benefit options you want to elect, review the insert Enrolling and follow the directions.

If you are enrolling for the first time, or if you would like to review your benefit options, read carefully through this workbook beginning with Medical Coverage on page 9. Then, review the insert Enrolling and follow the directions.

If you are married, review the benefits provided by your spouse's employer before enrolling. This will ensure that you complement, rather than duplicate, your benefit coverages.

If you cover yourself, your spouse, your dependents, or domestic partner, under your university medical plan in addition to any other medical coverage (including other university coverage or Medicare), you may be required to provide Humana with information about your other coverage.

2. The second section of this workbook contains information related to leaves of absence and termination of employment.

When Coverages End explains when each of your Choice Benefits coverages will end if your employment is terminated, either by you or the university. It also lets you know if you can continue your coverages beyond your employment.

Extending Benefits Through COBRA explains the Consolidated Omnibus Budget Reconciliation Act. COBRA is federal legislation that lets eligible employees and their enrolled dependents extend their health care benefits in the event they become ineligible for Choice Benefits.

The Family and Medical Leave Act (FMLA) explains government legislation that lets you take up to 12 weeks of unpaid leave to deal with certain family or medical situations such as care of a new child or sick family member.

The Health Insurance Portability and Accountability Act (HIPAA) explains government legislation that describes how medical information about you may be used and disclosed and how you can gain access to this information.

Partners in Controlling Costs

Our benefits program is a partnership between UC and its employees. We do everything we can to provide you with high-quality benefits at a reasonable cost to you and the university. This is how we do our part to keep costs down:

- **Competitive rates.** We use our buying power to negotiate competitive rates with health care providers.
- **Quality providers.** We monitor the quality of care and services provided by our selected providers.
- **Quality plans.** We maintain benefits programs that are fair and responsive to our employees' needs.
- **Low administrative costs.** We reduce administrative costs whenever feasible.
- **Employee education.** We provide educational materials so you can make appropriate benefit choices.

Every employee can make a difference, too. By using your benefits wisely, you can make a difference in the overall cost of your benefits.

Changing Choices After Enrollment

The benefit options you select now become effective on January 1, 2009 and will continue until December 31, 2009, based upon eligibility. You can make changes for 2010 during the enrollment period next fall. Otherwise, you may change your choices only if you have a qualified status change and submit appropriate documentation.

The following qualified status changes allow you to request certain benefit changes before the next enrollment period:

- ◆ birth, adoption of a child, or the placement of a child for adoption,
- ◆ death of a covered dependent,
- ◆ marriage,
- ◆ divorce, legal separation, or annulment,
- ◆ a change in domestic partner status
- ◆ a change in your, your spouse's, your dependent's, or domestic partner's employment that affects benefits (including an unpaid leave of absence, strike or lockout, or annual enrollment),
- ◆ loss of dependent eligibility due to age, or change from full-time student status or tax-exemption status,
- ◆ issuance of a court order or administrative decree requiring coverage of a dependent child,
- ◆ a significant increase or decrease in the cost of your benefits,
- ◆ relocation of your, your spouse's, your dependent's, or domestic partner's home or worksite (only if you had previously selected HMO coverage and the move takes you out of the HMO's service area)
- ◆ you, your spouse, your dependent or domestic partner enroll in Medicare, or
- ◆ a change of daycare provider that affects cost.

In addition, your benefit change must be consistent with the type of qualified status change. The type of benefit change permitted depends on the type of coverage involved.

You must contact the Human Resources Service Center of a qualified status change within 31 days of the qualified status change.

Your coverage category change and other changes become effective on the date of the qualified status change.

If you miss the 31-day deadline, you must wait until the next annual enrollment period or your next qualified status change to request the change.

Federal Legislation Affecting Your Medical Plan

Women's Health and Cancer Rights Act.

This act requires your medical plan to provide mastectomy benefits to cover the following procedures:

- ◆ Reconstruction of the breast on which the mastectomy was performed,
- ◆ Reconstructive surgery of the other breast to present a symmetrical appearance, and
- ◆ Prostheses and coverage for physical complications at all stages of the mastectomy procedure, including swelling associated with the removal of lymph nodes.

This change only affects the procedures in connection with mastectomy procedures. It does not extend treatment for surgeries, which are deemed to be cosmetic in nature, such as breast augmentation.

Newborns' and Mothers' Health Protection Act.

This act requires your medical plan to provide hospital stays in connection with childbirth of no less than 48 hours for vaginal deliveries and no less than 96 hours for deliveries by Caesarean section. Any exceptions to these minimum stay requirements must be made by the attending physician in consultation with the mother (or the newborn's authorized representative).

All copayments, deductibles, co-insurance, and precertification requirements are still applicable according to your medical plan's guidelines.

Coverage	You can
Medical	<ul style="list-style-type: none"> ◆ Change your option ◆ Change your coverage category (self, self plus one, family, self plus domestic partner, family plus domestic partner) ◆ Add or delete dependents
Flexible Spending Accounts	<ul style="list-style-type: none"> ◆ Start or stop contributions ◆ Increase or decrease contributions within account limits

Medical Coverage

Spouse or Domestic Partner Premium Surcharge

A \$50 monthly spouse or domestic partner surcharge will be added to your premium if you have elected to cover your spouse or domestic partner and he/she is eligible for medical coverage through his/her employer but chooses not to enroll. You will indicate if the Spouse or Domestic Partner Surcharge applies to you when you enroll for coverage. See Enrollment Instructions worksheet. If no election is made you **will** be charged the premium surcharge.

Medical Waiver

The Medical Waiver option should be chosen only after careful consideration. Even though you may choose the waiver if you are not covered by another medical plan you run the risk of potentially catastrophic medical expenses in the event of serious illness or injury. If you choose the Medical Waiver, you may not enroll in medical coverage during 2009 unless you have a qualified status change (QSC) and the change of plan must be consistent with the QSC. For example, if you choose the waiver of medical insurance and go on an unpaid leave of absence, you may not select medical coverage because the change is not consistent with the QSC.

HMO

This health maintenance organization (HMO) uses the Humana network of health care providers and covers a wide range of services. A provider directory may be accessed by logging on to the network provider or UC Web sites listed on the inside back cover.

To receive HMO benefits, you must follow these guidelines:

- ◆ You do not need to choose a Primary Care Physician.
- ◆ You may use HMO specialists without a referral.
- ◆ If you use a physician or facility that is not a participating provider in the HMO network, benefits will not be paid. However, in a true emergency, care for a life-threatening illness or accidental injury out of the service area is covered, provided you notify the plan within 48 hours.
- ◆ Check with your physician(s) to ensure the drugs prescribed are listed on the formulary. **All** prescriptions must be written by a **participating physician**.

The Medical Coverage Comparison later in this section summarizes the HMO benefits.

First 1000

This is a Point of Service (POS) plan which uses the Humana network of health care providers. A provider directory may be accessed by logging on to the network provider or UC Web sites listed on the inside back cover.

First 1000 is a consumer-driven medical plan for those employees who generally experience few medical expenses and are willing to pay out-of-pocket for medical expenses within the plan limits in return for a lower premium. The plan provides coverage for catastrophic medical expenses. The plan provides a \$500 annual benefit allowance per person to cover physician, hospital, and laboratory services, x-rays, preventive and wellness care. You are responsible for all copays, which are not covered by the benefit allowance, and eligible expenses until the deductible and out-of-pocket limits are met. **The First 1000 option should be chosen only after careful consideration.** Please refer to the Medical Coverage Comparison and the Humana First 1000 insert for details.

To receive the highest level of benefits under this POS, you must use the provider network; however, you do not need to choose a primary care physician.

You may use providers outside of the POS network; however, you will pay a greater share of eligible medical expenses. In a true emergency, care for a life threatening illness or accidental injury by an out-of-network provider will be covered at network benefit levels, provided you notify the plan within 24 to 48 hours.

No matter which health care provider you use, you must follow specific plan guidelines.

Limitations

All medical plans have certain limits and exclusions that apply to the services they cover. Limitations that the plans have in common include:

- ◆ A medically appropriate length of stay will be authorized whenever you or a family member is admitted to the hospital.
- ◆ During each hospital stay, the plan will periodically review the need for continued inpatient care to avoid unnecessary hospitalization.
- ◆ Special rules apply if you or a covered dependent is hospitalized when new coverage begins. Contact the HRSC for more information.
- ◆ Some prescription drugs may require pre-authorization.
- ◆ Each plan has special cost-management features that apply to mental health and substance abuse treatment.

Limits that are unique to a plan are summarized on the Medical Coverage Comparison later in this section. If you need emergency medical care outside the area serviced by the medical plans, keep in mind that benefits for this care may be limited.

Medical Coverage Comparison

Benefit	HMO*	First 1000**	
		Network	Non-Network
Benefit Allowance	NA	\$500 Benefit allowance per member per calendar year. Applies to medical services received from network providers only. Does not apply to copays, prescription copays, or Mental Health and Substance Abuse benefits.	NA
Deductible	No deductible	\$1,000 per person, \$3,000 per family	\$3,000 per person, \$9,000 per family
Copayment	As specified	As specified	As specified
Out-of-Pocket Limit	NA	\$2,000 per person \$6,000 per family	\$6,000 per person \$18,000 per family
Maximum Benefit	No maximum on most benefits; some benefits have calendar-year limits	\$5,000,000 network and non-network combined	\$5,000,000 network and non-network combined
Professional Services			
<i>The following amounts are what the applicable plan pays, less copayments and deductibles.</i>			
Allergy Testing and Treatment/Serum	20% copay, allergy testing only 100% allergy injections 100% serum coverage	Allergy testing 100% after \$15 copay; allergy injections 100% after \$5 copay; allergy serum 80% after deductible	Allergy testing and allergy injections 70% after deductible; allergy serum 60% after deductible
Diagnostic Tests and X-Rays	100%	80% after deductible	60% after deductible
Immunizations	100%	100% after deductible	70% after deductible
Maternity Care	\$10 copay for first visit only by participating providers at participating facilities	\$15 copay, first visit only	70% after deductible
Infertility Services	80% Covers diagnostic services; does not cover fertility drugs, reversal of voluntary sterilization, or services performed specifically to induce pregnancy; limited to \$2,000 per covered person per calendar year.	No coverage	No coverage
Office Visits	\$10 copay per visit/medical treatment Specialist services do not require a referral	\$15 copay	70% after deductible
Routine Physical Exams (including associated diagnostic tests and X-rays)	\$10 copay per visit	\$15 copay per visit; 80% after deductible for associated diagnostic tests, X-rays and laboratory services	70% after deductible; 80% after deductible for associated diagnostic tests, X-rays and laboratory services
Surgery	100%	80% after deductible; outpatient surgery facility charge: 100% after \$50 copay and after deductible	60% after deductible; outpatient surgery facility charge: 70% after deductible
Therapy Services (e.g. Physical, Speech, Occupational)	Short-term therapy: 100% for 60 visits per calendar year	80% after deductible	60% after deductible
Well-Baby/Well-Child Care	\$10 copay per visit/medical treatment	\$15 copay	70% after deductible
Eye Exams	\$10 copay per visit	No coverage	No coverage
Lenses and Frames	Discounts available through participating vision care providers	Discounts available through participating vision care providers	No coverage
Chiropractic Services	\$10 copay per visit/medical treatment Pre-authorization required. Maximum 20 visits per calendar year.	No coverage	No coverage

Exclusions and Limitations:

All plans are subject to exclusions, limitations and periodic updates.

For details on the HMO or First 1000, contact Humana Customer Service at ☎ 800-992-5780.

For details on vision care for the HMO and First 1000, contact EyeMed Visioncare Discount Program Customer Service at ☎ 877-226-1115.

* Services under the HMO must be provided by participating providers and plan-approved. Any services performed outside the plan's specifications may not be covered at the amount listed in this summary. All services must be medically necessary. Pre-approval must be obtained for all non-routine services.

+ For details on the HMO or First 1000 Mental Health and Substance Abuse Care, contact Alliance Behavioral Care Customer Service at ☎ 800-926-8862.

Medical Coverage Comparison (continued)

Benefit	HMO *	First 1000**	
		Network	Non-Network
Hospital Services <i>The following amounts are what the applicable plan pays, less copayments and deductibles.</i>			
Ambulance	100%	80% after deductible	60% after deductible
Anesthesia	100%	80% after deductible	60% after deductible
Emergency Care	\$50 emergency room copay (waived if admitted)	100% after \$100 copay and after deductible (copay waived if admitted)	70% after deductible
Skilled Nursing Facilities	100% for 365 days	80% after deductible. Maximum 60 days per calendar year, network and non-network combined	60% after deductible. Maximum 60 days per calendar year, network and non-network combined
Room and Board	100% semi-private; private room if medically necessary; no day limit	100% after \$100 copay per day for first 5 days per admission and after deductible***	70% after deductible***
Other Services <i>The following amounts are what the applicable plan pays, less copayments and deductibles.</i>			
Mental Health Care	These services are subject to special authorization and approval requirements before services are received. NOTE: This coverage is for short-term therapy only. Chronic mental health conditions are not covered. +	These services are subject to special authorization and approval requirements before services are received. +	These services are subject to special authorization and approval requirements before services are received. +
Inpatient	100%; maximum 45 days per calendar year	100% after \$100 copay per day for first 5 days per admission***; maximum 20 days per calendar year for network and non-network combined	70% after deductible***; maximum 20 days per calendar year for network and non-network combined
Outpatient	\$20 copay per visit. Maximum 20 visits per calendar year; excludes long-term psychotherapy	\$15 copay; Maximum 20 visits per calendar year for Mental Health and Substance Abuse combined	70%; Maximum 20 visits per calendar year for Mental Health and Substance Abuse combined
Substance Abuse Care	These services are subject to special authorization and approval requirements before services are received. +	These services are subject to special authorization and approval requirements before services are received. +	These services are subject to special authorization and approval requirements before services are received. +
Inpatient	Detoxification: 100% Rehabilitation: 1 inpatient stay per lifetime (maximum 45 days), if program completed	100% after \$100 copay per day for the first 5 days per admission***	70% after deductible***
Outpatient	1 outpatient program per lifetime, if program completed	\$15 copay; Maximum 20 visits per calendar year for Mental Health and Substance Abuse combined	70%; Maximum 20 visits per calendar year for Mental Health and Substance Abuse combined
Prescription Drugs	\$7 generic/\$12 name brand/\$24 non-formulary generic or name brand copay per prescription. Retail pharmacy or mail order for a 90-day supply: \$14 generic/\$24 name brand/\$48 non-formulary generic or name brand copay per prescription (including diabetic insulin, needles and syringes); 20% copay for diabetic supplies such as lancets, pen needles, test strips and autolet devices (mandatory generic).	\$10 generic/\$20 name brand/\$30 non-formulary generic or name brand copay per prescription. Retail pharmacy or mail order for a 90-day supply: \$20 generic/\$40 name brand/\$60 non-formulary generic or name brand copay per prescription (including diabetic insulin, needles and syringes) 80% diabetic supplies such as lancets, pen needles, test strips and autolet devices. Excludes drugs not requiring a prescription (except injectable insulin), drugs administered while hospitalized or covered by Workers' Compensation, and therapeutic devices and appliances.	\$10 generic/\$20 name brand/\$30 non-formulary generic or name brand copay per prescription. Retail pharmacy or mail order for a 90-day supply: \$20 generic/\$40 name brand/\$60 non-formulary generic or name brand copay per prescription (including diabetic insulin, needles and syringes)
Durable Medical Equipment	80% for conditions occurring after the effective date of coverage	80% after deductible. Pre-authorization required before services are received	70% after deductible. Pre-authorization required before services are received

Exclusions and Limitations (continued):

** To receive maximum benefits under First 1000, eligible services must be provided by participating providers. Any services provided outside the plan's specifications may not be eligible for benefits. All non-network services under First 1000 are subject to Usual, Customary, and Reasonable (UCR) limits are determined by the insurance company and subject to change. Acceptance of UCR limits is at the discretion of the non-network provider. If the non-network provider does not accept the UCR limit, you are responsible for any amount not covered by UCR in addition to the deductible, copay and out-of-pocket limit.

*** Advance approval is required. The plan must be notified immediately upon emergency admission. A medically appropriate length of stay is assigned for each admission, and the need for continued hospital stay is assigned during the admission to avoid unnecessary hospital stay. Case management may authorize coverage for lower-cost treatment alternatives which are also medically appropriate.

Prescription Drug Program

For those employees who choose the HMO or First 1000 Choice Benefits incorporates a prescription drug program which is subject to coordination of benefits with other medical or prescription plans. If your spouse, dependents, or domestic partner are covered by another medical or prescription plan, and that plan is considered primary, their prescriptions must be processed through their medical or prescription plan. If that plan's copay or coinsurance is more than your Humana plan, you may submit the receipt or Explanation of Benefits (EOB) to Humana for the difference between that plan's copay or coinsurance and your Humana copay.

In order to fill a prescription for a covered medication, you must follow these steps:

1. Go to your pharmacy.
2. Present your medical plan card and written prescription to the pharmacist. You should also present your card when ordering a refill.
3. Pay the copayment required by the medical plan.

If your prescription is for maintenance drugs, you can receive a 90-day supply at a participating retail pharmacy or through the mail order prescription drug program, at the cost of just two copayments. If using the mail order program, mail your 90-day prescription, along with the paperwork, to the address on the form. The prescription will be mailed to the address you request.

Keep In Mind

If you elect to contribute to the Health Care Account, you can use it to reimburse deductibles, copayments, and other eligible expenses not covered by your medical plan.

Flexible Spending Accounts (FSAs)

What They Are

Flexible spending accounts (FSAs) allow you to save money on taxes while you pay for certain kinds of eligible expenses. Under an FSA, you set aside money from your pay to cover eligible expenses before taxes are calculated and withheld. This money can be used to reimburse you for these eligible expenses.

FSAs are optional; you can enroll in one or both of these accounts:

- ♦ **The Health Care Account** lets you set aside tax-free money to pay for certain health care expenses not covered by health care plans.
- ♦ **The Dependent Daycare Account** offers you a tax break on daycare expenses for eligible dependents. The IRS offers another option that provides a taxbreak on these kinds of expenses. For details, see Another Daycare Tax Credit Option in this section.

The effective date of the flexible spending accounts is the effective date shown online.

Remember, if you are contributing to an FSA in 2008 and you want to continue contributing in plan year 2009, you must re-enroll online.

How They Work

If you decide to enroll in either or both accounts, your contributions are deducted from your paycheck before you pay any federal, state, city, or Medicare taxes. Because your taxes are calculated on a lower income, you should pay less tax.

During the year, you pay eligible health care and dependent daycare expenses, then request reimbursement from your account. The minimum reimbursement request is \$25, and the reimbursed money is tax-free.

The eligibility of an expense is determined by the date on which the health care or daycare service was provided, not by the date you pay the bill.

For example, if you incur an eligible medical expense in December 2009, but don't pay the bill until January 2010, that expense is considered a 2009 expense. Therefore, you can be reimbursed under your 2009 health care account.

You have until March 31, 2010 to request reimbursement for eligible expenses with a date of service from January 1, 2009 through December 31, 2009. You forfeit any remaining account balance if 2009 claims are not submitted by March 31, 2010.

You will be able to carryover any unused account balance from 2009 to 2010 for the health care and dependent daycare accounts. You will have from January 1 to February 28, 2010, the grace period, to incur expenses with a date of service within the grace period to use up your 2009 account balance.

Note: A 2010 eligible claim incurred within the grace period and submitted by March 31, 2010 will reduce the unused account balance carryover from 2009. If you submit eligible 2009 claims and they reduce your balance carryover to zero before you submit any remaining 2009 claims, the 2009 claims will not be reimbursed.

Here's an example of the tax benefit of these accounts based on 2008 federal tax brackets, and standard deductions and exemptions. Assume an employee and spouse file a joint tax return, have one child, and earn a family income of \$50,000. Assume also that the employee contributes \$500 to the health care account and \$2,000 to the dependent daycare account.

	Without the FSAs	With the FSAs
Family income	\$50,000	\$50,000
Health Care Account	—0	—500
Dependent Daycare Account	—0	—2,000
Taxable income	\$50,000	\$47,500
Federal income tax	—3,947	—3,572
Ohio state tax	—1,587	—1,470
Cincinnati tax	—1,050	—998
Medicare tax	—725	—689
Net income	\$42,691	\$40,771
Health care and daycare expenses	—2,500	—0
Spendable Income	\$40,191	\$40,771
Increase in spendable income		\$580

By using the health care account and the dependent daycare account, this family increases its spendable income by \$580 a year. Keep in mind that this is only an example. You should look carefully at your own financial situation before you decide to enroll in either account.

Dependent Daycare Account Eligibility

You may participate in the Dependent Daycare Account if you have a qualified dependent, are actively at work, and one of the following applies:

- ◆ you are single,
- ◆ you have a spouse who also works or goes to school full-time at least five months during the year while you're at work,
- ◆ you have a disabled spouse who can't care for himself or herself, or
- ◆ you are a divorced or legally separated parent who has custody most of the time, even though the other parent may claim the dependent for tax purposes.

A qualified dependent is:

- ◆ any person under age 13 whom you claim as a tax exemption (unless you are a divorced parent who has custody and the other parent claims the child as a dependent for tax purposes), or
- ◆ your spouse or any other dependent who is unable to care for himself or herself and who spends at least eight hours per day in your home.

Special Dependent Daycare Rule

The Dependent Daycare Account lets you use pre-tax money to pay for dependent care, if that daycare makes it possible for you to work. However, the account will not cover the full cost of care provided by a "specialty" daycare center.

For example, if you send your child to a summer "soccer camp," where the child learns to play soccer and also receives daycare, the account will cover only those expenses directly related to the daycare. Expenses related to teaching the child to play soccer are not covered.

Eligible Expenses and Limits

	Health Care Account	Dependent Daycare Account
Eligible Expenses	Generally, any health care expenses that are eligible for an income tax deduction under IRS regulations. Some expenses that might be eligible include: <ul style="list-style-type: none"> • medical and dental deductibles and copayments • orthodontia expenses not covered by a dental plan • hearing aids and batteries • eyeglasses • contact lenses and solutions • weight loss • LASIK eye surgery • over-the-counter drugs such as for allergies, acid reflux, and control of pain (aspirin, acetaminophen, and ibuprofen) 	You must meet certain requirements to be eligible for this account. See <i>Dependent Daycare Account Eligibility</i> for details. Daycare for your qualified dependent includes: <ul style="list-style-type: none"> • care provided in your home or in a licensed dependent care center. The center must be licensed by the state if more than six people are cared for there. • care provided by a housekeeper as part of his or her job.
Ineligible Expenses	<ul style="list-style-type: none"> • non-prescription drugs, except as noted above • mileage and parking • health care plan premiums • cosmetic surgery (unless it is necessary to correct a deformity resulting from a congenital abnormality, injury or disfiguring disease, or to restore bodily function). 	<ul style="list-style-type: none"> • care provided while you are on a leave of absence • overnight expenses for summer camp • care provided by your spouse, your child under age 19, or anyone you claim as a tax exemption.
Minimum Annual Contribution	\$120	\$120
Maximum Annual Contribution	\$2,400	Your tax filing status determines your maximum contribution amount: <ul style="list-style-type: none"> • single, filing under single or head of household: \$5,000 • married, filing jointly: the lowest of these three amounts—\$5,000, your income or your spouse's income* • married, filing separately: \$2,500
Reimbursement Limits	You can be reimbursed the full amount of your account at any time during the year.	You can only be reimbursed up to the amount you have contributed by the date you request reimbursement.

Exclusions and Limitations:

* If your spouse is a full-time student, or if a handicap prevents your spouse from working, his or her income is assumed to be \$200 per month if you have one dependent, or \$400 per month if you have two or more dependents.

Getting Reimbursed

To request reimbursement, you may submit claims electronically as an e-mail attachment, or use the claim form available online or from the Human Resources Service Center. You must submit receipts, Explanation of Benefit statements, or some other proof that you have incurred and paid the eligible expense. You must also provide the taxpayer identification number (TIN) of any daycare center or any person who provides dependent care if you are requesting reimbursement for those services.

You can check online if a claim has been processed and check your account balance. Your request for reimbursement after the end of plan year 2009 must be postmarked no later than March 31, 2010. The minimum reimbursement request is \$25, except for the last reimbursement of the year.

Direct deposit of your reimbursement to your saving or checking account is fast and convenient.

IRS Rules Apply

Because FSAs offer such a significant tax break, the Internal Revenue Service (IRS) applies these strict rules to their use:

- ◆ You may carryover any unused account balance from 2009 to 2010. You will have from January 1 to February 28, 2010, the grace period, to incur expenses with a date of service within the grace period to use up your 2009 account balance. You can request reimbursement for eligible expenses against your 2009 account until March 31, 2010. You forfeit any remaining amount of your 2009 account balance if eligible claims are not submitted by this date.
- ◆ If you terminate employment or become ineligible for Choice Benefits, you may be reimbursed only for expenses you incurred before your termination or ineligibility date. You may, however, continue participating in the Health Care Account (on an after-tax basis) through COBRA.
- ◆ You cannot transfer money from one account to the other.
- ◆ You cannot change the amount of your contributions during the year unless you have a qualified status change. Then if you increase your contribution amount, the increase is available only for expenses incurred after the date of the qualified status change.
- ◆ Because the plan is subject to IRS rules, you may be subject to certain eligibility requirements.

Another Daycare Tax Credit Option

As an alternative to the Dependent Daycare Account, IRS regulations offer another option: the federal tax credit for dependent care.

Federal Tax Credit: You cannot claim a federal tax credit for dependent care and request reimbursement from the Dependent Daycare Account for the same expense. In addition, expenses reimbursed from the account reduce, dollar for dollar, the amount of dependent care expenses you may apply to the federal tax credit. Therefore, you must choose one method or the other. Consult your financial advisor to determine which is better for you to use.

If you and your spouse file taxes separately, you may not use the federal tax credit.

Keep In Mind

- ◆ You may not claim a tax deduction or tax credit for any expenses reimbursed through the flexible spending accounts.
- ◆ The IRS requires you to file an additional form if you elect to use the Dependent Daycare Account. If you use Form 1040 to file your federal income taxes, you must also file Form 2441. If you use Form 1040A, you must attach Schedule 2 to your income tax return.
- ◆ The date an eligible expense is *incurred* (not paid) determines whether it is reimbursable. Expenses incurred in 2009 are reimbursable from your 2009 account. **You have until March 31, 2010 to request reimbursement for expenses with a date of service from January 1, 2009 through December 31, 2009.** Also, you may carryover any unused account balance from 2009 to 2010. You will have from January 1 to February 28, 2010, the grace period, to incur expenses with a date of service within the grace period to use up your 2009 account balance. You can request reimbursement for eligible expenses until March 31, 2010. You forfeit any remaining amount in your 2009 account balance if eligible claims are not submitted by this date.
- ◆ If you knowingly submit an ineligible expense for reimbursement, that action could constitute fraud. In such cases, the reimbursement claim will be denied and you could be subject to disciplinary action, including termination of employment.
- ◆ If you receive reimbursement for an expense that is later found to be ineligible, the university will seek full repayment of the amount of reimbursement.

Tuition Remission

Our Tuition Remission Program enables you to benefit from the many educational opportunities offered by the university. If you take advantage of this program, you will not pay instructional fees for university course work up to certain limits; however, you will pay any extra fees, such as late fees or room and board.

If you enroll in graduate courses, you will be subject to income taxes on the value of the tuition remission, if in excess of \$5,250 in a calendar year. The taxes will be deducted from your paycheck.

Eligibility

The following chart summarizes the tuition remission benefits that are available to university annually appointed adjunct faculty.

If you are	Your term tuition remission benefits are
Annually appointed adjunct faculty	<ul style="list-style-type: none"> • 3 credit hours per employee

You may “carry over” your unused tuition remission benefits for use in future terms. You may accumulate up to 11 credit hours, and you must use your accumulated credit hours within the term you accrue them or no later than the three terms subsequent to the term you accrued them. Any accumulated credit hours not used within the above time frame will be forfeited.

Limitations

Certain limits apply to tuition remission benefits. For example, students who apply for financial aid, such as grants, loans, or scholarships, must contact the Student Financial Aid Office. Keep in mind that tuition remission may affect eligibility for other forms of student aid.

You may be required to repay a portion of your tuition remission benefit for any class in which you withdraw. See www.uc.edu/registrar.

If your eligibility status changes during an academic term, tuition remission will continue for the remainder of that term. Any ineligible person who applies for and receives tuition remission will be billed and held accountable for payment.

When Coverages End

The benefit elections you make during this enrollment period will remain in effect until December 31, 2009, as long as you remain an eligible employee of the university. If your employment is terminated either by you or the university, your coverages will also end.

The table below shows when your coverage under each benefit plan would end if your employment were terminated. It also shows what options you would have to continue that coverage after termination.

Benefit	When Coverage Ends	Option To Continue
Medical	Last day of the month in which employment ends	Through COBRA
Flexible Spending Accounts	Last day of the month in which employment ends	Contributions may continue to the Health Care Account under COBRA on an after-tax basis. No claims incurred after termination may be submitted for reimbursement, except if continued under COBRA.
Tuition Remission	Last day of term in which employment ends	None

Extending Benefits Through COBRA

What It Is

COBRA is federal legislation that gives employees and their families an opportunity to continue health coverage due to a qualified event resulting in a sudden loss of health insurance. It lets employees and/or eligible dependents purchase (on an after-tax basis) an extension of their university medical, dental and health care flexible spending account benefits. **A domestic partner is not eligible to continue benefits under COBRA.** Also, employees are eligible for the benefits of the university's employee assistance program, REACH.

How It Works

Employees and/or their dependents are eligible for continuation of coverage under COBRA if they are enrolled in university benefits and experience one of the qualifying events listed in the table below. If a qualifying person elects COBRA coverage, it will be similar to the coverage that person had through the university the day before the qualifying event occurred.

After a qualifying person is enrolled in COBRA, that person can change their benefit elections just as they could while they were enrolled in university benefits — such as during annual enrollment or within 31 days of a qualified status change, if enrolled in a COBRA medical and/or dental plan. No one who applies for COBRA will be asked to furnish evidence of insurability. If a qualifying person does not elect to extend coverage through COBRA, their benefits will end.

In-Between Coverage

Qualifying persons must pay for any medical expenses they incur between the time their university benefits end and when they pay their first COBRA premium. However, COBRA will retroactively cover any out-of-pocket medical expenses once the first premium payment is made, provided the expenses incurred are covered by that person's COBRA benefits.

Cost

Qualifying persons pay the entire cost of extended coverage, plus a 2% administration fee.

The cost would be higher if the additional 11-month extension (as previously described) is elected due to a disability. The cost during that period would be 150% of the plan's cost at the time of the qualifying event for each person who extends coverage.

Payment is due the first of each month with a grace period of 30 days. Qualifying persons have 45 days from their date of election to pay the premium in full.

Qualifying Events

In the event that	Coverage may continue for	For up to
An employee's employment is terminated for any reason (except gross misconduct)	The employee and his/her eligible* dependents	18 months**
An employee's hours are reduced and the employee loses benefits	The employee and his/her eligible* dependents	18 months**
An employee dies	The employee's eligible* dependents	36 months
An employee gets a divorce or legal separation from his/her spouse	The spouse and the employee's eligible* dependents	36 months
An employee's child is no longer eligible for benefits	That eligible* dependent	36 months
An employee becomes enrolled in Medicare benefits	The employee's eligible* dependents	36 months

Exclusions and Limitations:

* Dependents are eligible for COBRA coverage if they were covered under university benefits the day before the qualifying event occurred. For COBRA purposes, newborn and adopted children are qualified beneficiaries with immediate enrollment rights.

** If an employee, or his/her dependents are disabled (as determined under the Social Security Act) within 60 days of a qualifying event, the employee and his/her dependents can extend coverage for an additional 11 months (total 29 months). However, the disabled person must notify the Human Resources Service Center and the appropriate insurance companies of the disability within the initial 18-month extension period and within 60 days after he/she receives notification that the disability is recognized by the Social Security Administration. Additionally, if an employee dies, becomes divorced or legally separated from his or her spouse, or eligible for Medicare during the initial 18-month period, his/her dependents can extend coverage for an additional 18 months based on the second qualifying event provided the Human Resources Service Center is notified within 60 days of the second qualifying event.

It is your responsibility to notify the University Human Resources Service Center within 60 days if you have a qualifying event.

Electing COBRA Coverage

To elect coverage continuation under COBRA, you must complete an election and return it to the University Human Resources Service Center within 60 days of the qualifying event. Each qualified person has a separate right to elect continuation coverage.

Qualifying persons generally have 60 days to elect an extension of benefits. This 60-day period begins on the later of these two dates:

- ♦ the date benefits end for the employee or dependent, or
- ♦ the date the employee, dependent is notified of his or her right to elect extended coverage.

The University Human Resources Service Center must be notified within 60 days if you have a qualifying event. If election for COBRA is not made within the 60-day period, eligibility for extended coverage under COBRA ends.

When Coverage Ends

Under certain circumstances, coverage under COBRA may be terminated during the extension period. COBRA coverage can be terminated if:

- ♦ the required premium payments are not paid in full on time,
- ♦ the qualifying person becomes covered as an employee under another group health plan,*
- ♦ a qualifying dependent becomes covered under another group plan,*
- ♦ the qualifying person or the employee's dependents become enrolled in Medicare benefits (COBRA coverage ends only for the person who is enrolled in Medicare),
- ♦ a qualifying disabled person loses disabled status as defined by the Social Security Act, or
- ♦ university benefits are terminated for all employees.

Once COBRA coverage ends, it cannot be reinstated.

* COBRA coverage can continue for the remainder of the COBRA coverage period if the other group health plan has a pre-existing condition exclusion that limits coverage. In this situation COBRA coverage can continue only for the qualifying person or the employee's dependent to whom the pre-existing condition exclusion applies.

Medicare Prescription Drug Notice

Your HMO and First 1000 Prescription Drug Coverage and Medicare 2009 Recertification

If you are enrolled in the University of Cincinnati HMO or First 1000, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the University of Cincinnati and the prescription drug coverage available for people eligible for Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage in the future.

Highlights

- ♦ Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare.
- ♦ The University of Cincinnati must recertify annually the qualification of its prescription drug coverage in relation to coverage provided under Medicare Part D.
- ♦ The University of Cincinnati has determined that the prescription drug coverage provided under the UC Humana medical plans, is on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage.
- ♦ While you are an active employee, the University of Cincinnati is required to pay as your primary insurer.

Effective January 1, 2006, prescription drug coverage became available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium. The University of Cincinnati has determined that your prescription drug coverage with Humana is expected to pay out as much as the standard Medicare prescription drug coverage.

As an active employee of the University of Cincinnati enrolled in existing coverage that, on average, is at least as good as standard Medicare prescription drug coverage, you do not need to enroll in Medicare Part D at this time. Since the university's plan is considered "creditable," you will not have to pay extra when you enroll at the termination of your eligibility with the University of Cincinnati (i.e. retirement) if you enroll within the limitations stated later in this notice.

People with Medicare can enroll and purchase a Medicare prescription drug plan. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you do not have to choose to join a Medicare prescription drug plan until you retire, resign, or lose eligibility to participate in medical coverage

You should know that if you drop or lose your coverage with the University of Cincinnati and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage your monthly premium will go up at least 1% per month for every month after May 15, 2006, that you did not have that coverage. For example, if you retire from the university and go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next November to enroll.

For more information about your future options under Medicare prescription drug coverage.

More detailed information about Medicare plans that offer prescription drug coverage is available in the current "Medicare & You Handbook" which you will receive in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can get more information about Medicare prescription drug plans from these places:

- ♦ Visit www.medicare.gov for personalized help.
- ♦ Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You Handbook" for their telephone number)
- ♦ Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help visit SSA online at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

This information was provided by the University of Cincinnati Human Resources Service Center, 51 Goodman Drive, Suite 340, Cincinnati, Ohio. For additional information on the medical and prescription plans available through the university, call the HRSC at 513-556-6381.

The Family And Medical Leave Act (FMLA)

What It Is

The FMLA is federal legislation that entitles eligible employees to take an unpaid leave of absence from work for up to 12 weeks to respond to qualifying events affecting individual and family needs.

Eligibility

You are eligible to take an FMLA leave after you have worked at least one year and also worked at least 1,250 hours over the previous 12 months (excluding use of any vacation or sick time).

How It Works

If you are eligible, you can take an FMLA leave of absence for these family and medical situations:

- ♦ care of your newborn child,
- ♦ care of your newly placed foster child or adopted child,
- ♦ care of your spouse, child, or parent (not parent-in-law) who has a serious health condition, or
- ♦ a serious health condition that makes you unable to perform the essential functions of your job.

If your spouse is also employed by the university, the amount of time you may both take during a 12-month period depends on the situation:

- ♦ **For care of your newborn or newly placed foster or adopted child**, the two of you are entitled to a combined 12 weeks.
- ♦ **For an ill child**, each parent can take 12 weeks of leave (or 24 weeks combined).
- ♦ **For ill parents**, the combined time you may both take is 12 weeks. For example, if you take 8 weeks to care for your ill parent, your spouse is entitled to only 4 weeks of leave in the event his or her parent becomes ill. You cannot take FMLA leave to care for your spouse's parent.

If you take a leave for the birth or placement of a child for adoption or foster care, that leave must end within 12 months of the birth or placement.

Serious Health Condition

A serious health condition is one that requires continuing treatment by a licensed health care provider or inpatient care at a hospital, hospice, or residential care facility.

Continuing treatment refers to the following situations:

- ◆ a period of incapacity that lasts for three consecutive days and requires:
 - two or more treatments by a health care provider, or
 - a single treatment by a health care provider followed by a supervised regimen of treatment.
- ◆ any period of incapacity due to pregnancy,
- ◆ a chronic condition that requires periodic treatment,
- ◆ a condition that requires multiple treatments (such as chemotherapy or dialysis), or
- ◆ a condition that is long-term or terminal.

Giving Notice

In cases where the need for leave is foreseeable, such as the birth of a child, you should give 30-days advance notice before your leave of absence may be approved. Otherwise, you should give notice within 2–3 days after learning of the need for a leave. Verbal notification will be accepted if sufficient need is shown.

About Your Benefits

Your benefits remain in effect while you are on an FMLA leave. You also continue to pay your share of the cost of your insurance coverages while you are on leave — even though you may not be getting a paycheck from which your contributions can be deducted. This means you will have to make arrangements with the University Human Resources Service Center to pay your share of premiums. If the required premiums are not received, insurance coverages will be terminated for the duration of the leave.

If you receive any paid leave benefits, such as accrued sick or vacation time, they must be used concurrently with an FMLA leave. The amount of paid or unpaid leave you take reduces your FMLA entitlement day for day.

When You Return

When you return, you will be reinstated to your former position or to an equivalent position with equal pay, benefits and other terms and conditions of employment. Your use of an FMLA leave cannot result in the loss of any employment benefit that you earned or were entitled to before the leave.

When you return from an FMLA leave in connection with a serious medical condition, you must submit:

- ◆ a medical statement from your health care provider to University Health Services, and
- ◆ a fitness-for-duty certification from a University Health Services physician to your department.

Applying For FMLA Leave

Requests should be signed by you and submitted to your dean, director, department head, or supervisor. In cases where the need for leave is immediate and unforeseen, verbal requests will be accepted.

Requests for leaves due to illness — whether the illness is yours or someone else's — must include:

- ◆ a Certification of Health Care Provider form, available from the Human Resources Service Center, stating the date on which the serious health condition started,
- ◆ the probable duration of the condition, and
- ◆ an explanation of the condition provided by the health care provider.

The form should be returned to University Health Services.

Requests for leaves due to illness of someone other than yourself must include a completed Certification of Health Care Provider form with an explanation of the type of care you will be providing and an estimate of the amount of leave you are requesting. The form should be returned to University Health Services.

Requests for leaves due to your own illness must include a completed Certification of Health Care Provider form stating that you are unable to perform the functions of your position and include an estimated return-to-work date. If you require an intermittent leave or reduced schedule, that need must also be documented along with the frequency, duration, and estimated return-to-work date. The form should be returned to University Health Services.

Requests for non-medical leaves should be signed by you and submitted to your dean, director, department head, or supervisor at least 30 days before the leave begins.

More Information

For more information, contact the HRSC.

How Leaves Affect Coverage

The table below shows what happens to your coverage under each benefit plan if you take a leave of absence and want to continue benefits.

Depending on the type of leave, changes selected during the annual enrollment for life insurance, long-term disability insurance, and the health care flexible spending account will not become effective until you return from leave. However, to receive the benefits that you select during annual enrollment, you must be in active pay status (including leaves of absence with pay) on the first day of the new plan year (January 1) or the election will not become effective until you return from unpaid status. To contribute to FSAs while on leaves of absence with pay, you must still meet the eligibility requirements of the FSAs. For example, if you are not working, you may not be eligible for the dependent daycare account.

Leaves with pay assume the use of vacation and/or sick time.

Benefit	Type of Leave					
	Personal leave without pay	Medical leave with pay	Medical leave without pay	Educational leave without pay	FMLA leave with pay	FMLA leave without pay
Medical	B	A	C	B	A	C
FSA – Health	NA	A	NA	NA	A	NA
FSA – Dependent	NA	NA	NA	NA	NA	NA
Tuition Remission	NA	D	D	D	D	D

A – Employee continues to make regular contributions by payroll deduction.

B – Employee must continue the employee's and/or employer's contribution.

C – Employee must continue making regular contributions, which would have been payroll-deducted if a regular paycheck had been issued.

D – Benefit continues.

NA – Not available.

If the required premiums are not received, benefits will be discontinued until you return to work. A break in coverage may affect benefits under plans with continuous coverage or pre-existing condition requirements.

Health Insurance Portability and Accountability Act (HIPAA)

What It Is

HIPAA is federal legislation effective April 14, 2003 that requires the University of Cincinnati Choice Benefits Plan (the “Plan”) sponsored by the University of Cincinnati to provide you with this notice regarding the plan’s legal duties and privacy practices with respect to your personal health information. This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. The Plan is required by law to abide by the terms as outlined hereafter.

Applicability

This Notice applies to the welfare programs including the medical, dental, prescription drug, vision, mental health, medical reimbursement spending account and employee assistance programs. **This Notice is informational only. No action is required on your part as a result of this Notice.**

Your Personal Health Information

The Plan may collect personal health information from or about you through the application and enrollment process, utilization and review activities, claims payment, and/or other activities in connection with the general management of the Plan. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual who is associated with the health information.

Uses or Disclosures of Your Personal Health Information

Generally, the Plan may not use or disclose your protected health information without your permission. There are, however, circumstances under which the plan is permitted by law to use or disclose your protected health information without your permission:

- ♦ The Plan may use or disclose your protected health information without your permission, in order to render benefit claim payments for those covered services that you may receive and to conduct other related health care operations in connection with the general management of the Plan. The Plan is permitted to disclose your protected health information within and among the persons performing services for the Plan.

- ◆ The Plan may also use or disclose your protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.
- ◆ Except as otherwise permitted or required, as described above, the Plan may not use or disclose your protected health information without your written authorization. You may revoke your authorization to use or disclose protected health information at any time, except to the extent that either the Plan has taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Your Rights With Respect to Your Protected Health Information

Under HIPAA, you have certain rights with respect to your protected health information. The following is a brief overview of your rights and the Plan's duties with respect to enforcing those rights.

Right To Request Restriction On Use Or Disclosure

— You have the right to request restriction on certain uses and disclosures of your protected health information. While the Plan is not required to agree to any requested restriction, if the Plan agrees to a restriction, the Plan is bound not to use or disclose your protected health care information in violation of such restriction, except in certain emergency situations. You cannot request uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications —

You have the right to receive confidential communications of your protected health information. The Plan may require such a request for confidential communications be made in writing.

Right To Inspect And Copy Your Protected Health Information — Your designated record set is a group of records the Plan maintains that includes enrollment, payment, claims adjudication, and care and medical management records. You have the right of access in order to inspect and obtain a copy of your protected health information contained in your designated record set. The Plan requires a written request for the access. The Plan must provide you with hard copy access to your protected health information if you request it and if it is available and, if not, in any other form reasonably available. If you request a copy of your protected health information or agree to a summary or explanation of such information, the Plan may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs for preparing an explanation or summary as agreed upon in advance. The Plan reserves the right to deny you access to and copies of certain protected health information as permitted or required by law.

Right to Amend your Protected Health Information

— You have the right to request that the Plan amend your protected health information or a record about you contained in your designated record set, for as long as the designated

record set is maintained by the Plan. All requests for amendment shall be sent to Privacy Officer, c/o University of Cincinnati Choice Benefits Plan at University Hall, Suite 340, 51 Goodman Drive, Cincinnati, OH 45221-0039.

Right to Receive an Accounting of Disclosures of your Protected Health Information — Beginning April 14, 2003 you have the right to receive a written accounting of all disclosures of your protected health information that the Plan has made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. *The Plan is not required to provide accountings of disclosures for the following purposes:* (a) payment and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) to persons involved in your care, and (e) with respect to disclosures occurring prior to April 14, 2003. All requests for an accounting shall be sent to Privacy Officer, c/o University of Cincinnati Choice Benefits Plan at University Hall, Suite 340, 51 Goodman Drive, Cincinnati, OH 45221-0039.

Complaints

You may file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to the Plan's Complaint Officer, c/o University of Cincinnati Choice Benefits Plan at University Hall, Suite 340, 51 Goodman Drive, Cincinnati, OH 45221-0039.

Amendments to this Privacy Notice

The Plan reserves the right to revise or amend this Notice at any time. These revisions or amendments may be made effective for all protected health information the Plan maintains even if created or received prior to the effective date of the revision or amendment. The Plan will provide you with notice of any revisions or amendments to this notice, or changes in the law affecting this notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Notice

The Plan will provide you with a copy of the most recent version of this notice at any time upon your written request sent to the Plan's Privacy Officer, c/o University of Cincinnati Choice Benefits Plan at University Hall, Suite 340, 51 Goodman Drive, Cincinnati, OH 45221-0039.

For any other requests or for further information regarding the privacy of your protected health information, and for information regarding the filing of a complaint with the Plan, please contact the Plan's Privacy Officer, c/o University of Cincinnati Choice Benefits Plan at University Hall, Suite 340, 51 Goodman Drive, Cincinnati, OH 45221-0039.

Questions

Our voice mail system is designed to help you get answers to your benefit questions. With the system, you can contact the HRSC or request any forms you may need.

The voice mail system and Web sites are accessible 24 hours a day, 7 days a week.

Contact Information

Employee Self-Service (ESS)	<i>www.ucflex.uc.edu</i>
Human Resources Service Center (HRSC)	<i>www.uc.edu/hr</i> 513-556-6381
POS, HMO and First 1000 Humana (medical, mail order drugs)	<i>www.humana.com</i> 800-601-5031
POS and HMO Vision	<i>www.eyemedvisioncare.com</i> 877-226-1115
POS Mental Health and Substance Abuse Care	<i>www.alliance-behavioral.com</i> 800-926-8862
HMO and First 1000 Mental Health and Substance Abuse Care	<i>www.humana.com</i> 800-601-5031
To set up a personal account for medical and dental	<i>http://uc.humana.com</i>
Dental plans	<i>www.humana.com</i> 800-233-4013
Flexible Spending Accounts	<i>www.chard-snyder.com</i> 800-982-7715

About this Enrollment Workbook

This workbook contains only the highlights of the Choice Benefits program and is subject to annual review and modification. The program itself and each plan are governed by an official plan document. In case of any conflict between this enrollment workbook and an official document, the plan document will be the final authority. For more detailed information about Choice Benefits or any of the options described in this workbook, contact the HRSC.



Human Resources Service Center

University Hall, 5th floor
PO Box 210039
Cincinnati, OH 45221-0039

513-556-6381

www.uc.edu/hr