

# Choice

## **B E N E F I T S**

Applicable to:

**Post Doc Fellows**

**Research Fellows**

# 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](http://www.ucflex.uc.edu).

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

**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 NEW 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 apply 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. You will not submit a paper form.

**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](http://www.uc.edu/hr).

**Enrollment Workbook on the Internet** — The Enrollment Workbook can be found online at [www.uc.edu/hr](http://www.uc.edu/hr).

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# Introducing Choice Benefits

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

## Who Is Eligible

Post doc fellows and research fellows may enroll in Choice Benefits if you are:

- a full-time employee,
- a part-time employee at 80 percent FTE or greater.

Your personal information, available online shows the options for which you are eligible. Your coverage begins 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, please respond promptly by returning the form directly to the Human Resources Service Center. It may also be necessary to provide the Human Resources Service Center with other documents such as:

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

If your dependent **maintains** full-time UC student status, you will receive a confirmation letter and 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 chart below outlines the eligibility rules for your dependents.

### 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.

### 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 coverages during the normal summer break, your child must be a full-time student in the quarter or semester 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 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.

Eligible Dependents	Medical	Dental
Your husband or wife.	yes	yes
Your domestic partner (see Domestic Partner section).	yes	yes
Your unmarried natural or legally adopted child or stepchild under age 19.	yes	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	yes
Your unmarried child from age 19 to age 23 who maintains full-time student status and is your IRS dependent.	yes	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	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	yes

#### Exclusions and Limitations:

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

## Value and Costs

The university works diligently to offer high-quality benefits to you and your family. The university covers the full cost of the benefits you select. However, if you decline coverage this enrollment period, you may increase your coverage only during the next annual enrollment period or upon a qualified status change.

## 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.

*If you are enrolling for the first time*, you will not be enrolled in any benefits.

- medical option — HMO for yourself only, and
- dental option — Basic Plan for yourself only.

## Domestic Partner Coverage

You may cover your domestic partner, opposite or same sex, for medical and dental 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
  - 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 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](http://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 value of medical and dental 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 cost for your domestic partner is the amount on which you will be taxed for covering your domestic partner for medical and dental insurance. Refer to your enrollment information for details on the value (cost) for self of the medical and dental 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,
- notify the Human Resources Service Center when your personal information changes (new address or beneficiaries or change in your family benefits covered by your spouse's employer),
- read the materials we provide to you,
- contact the HRSC when you have questions about your benefits,
- contact the Human Resources Service Center within 31 days of the date of a qualified status change (e.g., marriage, new dependents) if 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.

## 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.

Coverage	You can
Medical	<ul style="list-style-type: none"> <li>• Change your option</li> <li>• Change your coverage category (self, self plus one, family, self plus domestic partner, family plus domestic partner)</li> <li>• Add or delete dependents</li> </ul>
Dental	<ul style="list-style-type: none"> <li>• Change from Dental Waiver to the Basic Plan</li> <li>• Change your coverage category (self, self plus one, family, self plus domestic partner, family plus domestic partner)</li> <li>• Add or delete dependents</li> </ul>

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 enrollment period or your next qualified status change to request the change.*

# Medical Coverage

## What It Is

Medical coverage pays benefits for eligible medical expenses. The medical coverage chart later in this section summarizes the benefits available under the medical plan. You should review it carefully.

## 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 the Enrollment Instructions worksheet. If no election is made and your spouse or domestic partner is enrolled on your medical coverage, you will be charged the premium surcharge.

## Medical Waiver

You do not have to certify you have other medical coverage in order to choose the waiver of medical insurance. *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.

## POS

If you live outside of the Humana network area (Greater Cincinnati area) contact the Human Resources Service Center at 513-556-6381.

## 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 at the end of this workbook.

To receive HMO benefits, you must follow these guidelines:

- You do not need to choose a primary care physician.
- You may use HMO network 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.*

## Limitations

The HMO has certain limits and exclusions that apply to the services it covers. Some of these limitations are:

- 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.
- Special cost-management features apply to mental health and substance abuse treatment.

Other limits are summarized on the Medical Coverage Chart later in this section. If you need emergency medical care outside the area serviced by the HMO, keep in mind that benefits for this care may be limited.

## Prescription Drug Program

For those employees who choose the HMO, 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 cost 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. This means you save the cost of one copayment. If using the mail order program, be sure your physician writes your prescription for a 90-day supply. Mail the prescription along with the paperwork to the appropriate address on the form. The prescription will be mailed to the address you request.

## Keep In Mind

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

*If you have a qualified status change that involves adding a dependent, your completed confirmation form indicating the addition of the dependent to your medical coverage must be received in the Human Resources Service Center within 31 days of the qualified status 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.

## Medical Coverage Chart

Benefit	HMO*
Deductible	No deductible
Copayment	As specified
Out-of-Pocket Limit	NA
Maximum Benefit	No maximum on most benefits; some benefits have calendar-year limits
<b>Professional Services</b> <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
Diagnostic Tests and X-Rays	100%
Immunizations	100%
Maternity Care	\$10 copay for first visit only by participating providers at participating facilities
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
Office Visits	\$10 copay per visit/ medical treatment; Specialist services do not require a referral
Routine Physical Exams (including associated diagnostic tests and x-rays)	\$10 copay per visit
Surgery	100%
Therapy Services (i.e., Physical, Speech, Occupational)	Short-term therapy: 100% for 60 visits per calendar year
Well Baby/Well-Child Care	\$10 copay per visit/medical treatment
Eye Exams	\$10 copay per visit
Lenses and Frames	Discounts available through participating vision care providers
Chiropractic Services	\$10 copay per visit/medical treatment; Pre-authorization required. Maximum 20 visits per calendar year.
<b>Hospital Services</b> <i>The following amounts are what the applicable plan pays, less copayments and deductibles.</i>	
Ambulance	100%
Anesthesia	100%
Emergency Care	\$50 emergency room copay (waived if admitted)
Skilled Nursing Facilities	100% for 365 days
Room and Board	100% semi-private; private room if medically necessary; no day limit
<b>Other Services</b> <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 <b>before</b> services are received. <b>NOTE:</b> This coverage is for short-term therapy only. Chronic mental health conditions are not covered. +
Inpatient	100%; Maximum 45 days per calendar year.
Outpatient	\$20 copay per visit. Maximum 20 visits per calendar year; excludes long-term psychotherapy.
Substance Abuse Care	These services are subject to special authorization and approval requirements <b>before</b> services are received. +
Inpatient	Detoxification: 100% Rehabilitation: 1 inpatient stay per lifetime (maximum 45 days), if program completed.
Outpatient	1 outpatient program per lifetime, if program completed.
Prescription Drugs	\$7 generic/\$12 name brand/\$24 non-formulary generic or name brand copay per prescription at any HMO-participating pharmacy. 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)
Durable Medical Equipment	80% for conditions occurring after the effective date of coverage.

### Exclusions and Limitations:

The plan is subject to exclusions, limitations and periodic updates.

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

For details on vision care for the HMO, 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 comparison.

All services must be medically necessary. Pre-approval must be obtained for all non-routine services.

+ For details on the HMO Mental Health and Substance Abuse Care, contact Humana Customer Service at ☎ 800-992-5780.

# Dental Coverage

## What It Is

Dental coverage helps you and your covered family members pay for eligible dental expenses. The Dental Coverage Chart below summarizes the benefits available under the dental plan.

## How It Works

- You may use any dentist you choose.
- All non-network dental benefits are based on the Usual, Customary, and Reasonable (UCR) charges for these services. UCR limits are determined by the insurance company and subject to change. Acceptance of the 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 and copay.
- For all covered services, you pay a deductible before your plan pays benefits.
- It is recommended your dental provider submit a pre-determination if the cost of your dental services will be \$200 or more. The insurance company will provide an estimate of the coverage amount based on the information submitted.
- After paying the deductible, you and the plan share the cost of most eligible expenses. The amount you pay is based on whether or not you use a dentist who is part of the plan's network. If you use a network dentist, your share of the cost is based on the dentist's discounted fees, so your costs are lower.

In addition, there is no balance billing when you use a network dentist. If you use a non-network dentist, your share of the cost is based on the dentist's full fee. A provider directory may be accessed by logging on to the network provider or UC Web sites listed at the end of this workbook.

No matter what dentist you use, the amount of your deductible, coinsurance levels, and plan maximum stay the same (for example, you pay 20 percent of the cost for restorative services).

- The plan limits the amount of benefits each covered person can receive during the plan year.
- An identification card will be issued; present your identification card to your provider for all dental services.
- A new dental plan will not cover certain ongoing treatment. The definition of on-going treatment differs by service. Contact the HRSC for information about on-going treatment.

## Keep In Mind

If you have a qualified status change that involves adding a dependent (for example, marriage, childbirth, or domestic partner), you must notify the Human Resources Service Center within 31 days of the qualified status change.

If you miss the 31-day deadline, you must wait until the next enrollment period or your next qualified status change to make this addition or change plans.

## Dental Coverage Chart

Benefit	Basic Plan
<b>Deductible</b>	\$50 per person \$150 per family (includes all services)
<b>Annual Maximum Benefit</b>	\$500 per person (includes all services)
<b>Preventive and Diagnostic Services</b>	80% (after deductible)  Covered services under each plan include: <ul style="list-style-type: none"> <li>Examinations, diagnosis and cleanings up to twice a year</li> <li>Bite-wing or full mouth X-rays</li> <li>Topical fluoride application for dependent children to age 16 (up to twice a year)</li> <li>Topical fissure sealants for dependent children to age 16</li> <li>Space maintainers to age 16</li> </ul>
<b>Restorative Services</b>	80% (after deductible)  Covered services under each plan include: <ul style="list-style-type: none"> <li>Emergency treatment for relief of pain</li> <li>Fillings (amalgam, synthetic porcelain and plastic restorations)</li> <li>Extractions and other oral surgery including pre- and post-operative care</li> <li>Anesthesia for restorative services</li> </ul>
<b>Major Services</b>	60% (after deductible)  Covered services under each plan include: <ul style="list-style-type: none"> <li>Root canals or treatment of diseases of the tooth pulp</li> <li>Treatment of the gums and supporting tissues</li> <li>Repair of full or partial dentures</li> <li>Dentures and bridges</li> <li>Crowns (plastic, veneer, gold)</li> <li>Gold restorations</li> <li>Relining and duplication of full or partial dentures</li> <li>Tooth implants</li> <li>Anesthesia for major services</li> </ul>
<b>Orthodontia Services</b>	Not covered

### Exclusions and Limitations:

The plans is subject to exclusions, limitations and periodic updates. For details on the plans, contact Humana Customer Service at 800-233-4013.

# 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 the instructional fee for university course work; 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 post doc and research fellows.

If you are	Your term tuition remission benefits are
A regular employee (FTE of 80% or greater)	<ul style="list-style-type: none"> <li>3 credit hours per employee*</li> </ul>

The effective date of tuition remission is the term or summer session that begins after the first day of the month following 28 days of employment.

## Limitations

Certain limitations 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 effect eligibility for other forms of student aid.

- You may be required to repay a tuition remission benefits for any class in which you withdraw. See [www.uc.edu/registrar](http://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 receive 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
Dental	Last day of the month in which employment ends	Through COBRA
Tuition Remission	Last day of the quarter 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.

## Qualifying Events

The table below shows when, for whom and how long coverage can be continued for qualifying persons.

## 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 percent 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 percent 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 POS Prescription Drug Coverage and Medicare 2009 Recertification

If you are enrolled in the University of Cincinnati HMO, 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 plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage.
- While 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 percent 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 percent 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](http://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](http://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.

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	FMLA leave with pay	FMLA leave without pay
Medical	B	D	D	D	D
Dental	B	D	D	D	D
Tuition Remission	NA	D	D	D	D

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

D — Benefit continues.

NA — Not available.

If the required premiums are not received, benefits will be discontinued until you return to work.

# 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

<b>Employee Self-Service (ESS)</b>	<i>www.ucflex.uc.edu</i>
<b>Human Resources Service Center (HRSC)</b>	<i>www.uc.edu/hr</i> 513-556-6381
<b>HMO Humana (medical, mail order drugs)</b>	<i>www.humana.com</i> 800-601-5031
<b>HMO Vision</b>	<i>www.eyemedvisioncare.com</i> 877-226-115
<b>HMO Mental Health and Substance Abuse Care</b>	<i>www.humana.com</i> 800-601-5031
<b>To set up a personal account for medical and dental</b>	<i>http://uc.humana.com</i>
<b>Dental Plan</b>	<i>www.humana.com</i> 800-233-4013

## 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](http://www.uc.edu/hr)*