

UNIVERSITY OF MISSOURI

# *Medical Benefit Plan*

Effective January 1, 2006



This booklet is designed to provide an overview of the University of Missouri's Medical Plan for active employees, employees on leave of absence, and disabled employees receiving long term disability benefits. This booklet is not applicable to retirees. While the University hopes to offer participation in these plans indefinitely, it has the right to amend or terminate any benefit plan. Such action may affect active and/or retired employees and may be in the form of benefits or contribution amounts. In addition to this booklet, we plan to continue to use other methods of communication such as memos, meetings, newsletter articles or electronic media to help you stay informed.

The plan is governed by a legal document called a plan document. The University has taken care to present the information contained in the plan document in a way that is both accurate and easy to understand. However, in the event of a disagreement between this booklet and the plan document, the plan document will be followed.

It's important for you to have a good understanding of all this plan has to offer. Please review this booklet carefully. If you have questions, contact your Campus Benefits Representative at the appropriate address or phone number shown below.

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# ***Introduction***

The UM Medical Benefit Plan offers employees and their eligible dependents financial protection against a wide range of health care expenses resulting from illness or injury.

As part of the University's continuing efforts to provide benefits to meet the varying needs of its employees, the medical benefits plan offers several programs to choose from. The available programs are:

- ◆ UM Choice Plus Point-of-Service Program
- ◆ Catastrophic Program
- ◆ Humana HMO (Kansas City Only)

Because the various networks are geographically based, all options are not available to every employee.

## ***The University of Missouri Choice Plus Point-of-Service Program***

With the UM Choice Plus Point-of-Service (POS) Program, you can choose whether to use a network or non-network physician or other health care provider each time health care services are needed. In other words, you decide at the “point of service”. However, you receive higher benefits when you receive care from a network provider. Network provider listings can be found online through the UM web site or in the provider directories.

With the UM Choice Plus POS Program, you do not select a primary care physician (PCP). You will receive network level benefits for care received from any provider in the UM Choice Plus national network.

## ***The Catastrophic Program***

For some individuals, the Catastrophic Program is the solution to their health care needs. The Catastrophic Program has a higher out-of-pocket limit and a higher deductible in exchange for a lower monthly cost. It is often the choice if you require less health care coverage because you have coverage under another health care plan or can afford the extra out-of-pocket costs. The Catastrophic Program provides the same benefits for care received from any qualified physician, hospital or other medical facility.

## ***Humana HMO***

The University of Missouri offers employees in the Kansas City area the choice of enrolling in the Humana HMO. Humana offers a wide range of services to participants and their dependents on a prepaid basis. Coverage is provided through network health care providers only, except in the case of an emergency.

# *Eligibility and Enrollment*

## *Employee eligibility*

If you are an active employee of the University, you are eligible for coverage provided you also meet the following conditions:

- You are classified 75% FTE (full-time equivalent) or more.
- You have an appointment duration of at least nine months.
- You are regularly scheduled to work at least 30 hours a week.

In addition, you are eligible for coverage under this plan if you are:

- disabled and are entitled to benefits under the University's Long Term Disability Plan (or would be entitled to benefits if you were enrolled under that plan),  
and
- vested in the University of Missouri Retirement, Disability and Death Benefit Plan.

A per diem employee is excluded as an Employee under this Plan.

## *Dependent eligibility*

*Note: Proof of relationship documentation is required for spouse and children to be covered.*

Your eligible dependents include your spouse and each of your unmarried natural children younger than age 19.

Children age 19 and older are also eligible for coverage if they meet one of the following requirements:

- They are unmarried, at least age 19 but less than age 23 and dependent on you or your spouse for principal support.
- They are unmarried, at least age 19 but less than age 25, full-time students at an accredited education institution and depend on you or your spouse for principal support.
- They are unmarried, dependent on you because of a physical or mental disability and are incapable of self-sustaining employment prior to reaching the maximum age for coverage as a dependent. In this situation, you must notify the University and submit proof of the child's status within 31 days of the date he or she would otherwise become ineligible. Disabled children may be covered by the plan as long as they remain incapacitated and dependent, and proof is submitted when requested.

In addition to your natural children, a child who lives with you in a parent-child relationship will be considered eligible under these conditions if he or she is placed in your home for legal adoption, or is a legally adopted child, stepchild or foster child and you are providing principal support.

For the purposes of this plan, an eligible foster child is a child for whom you or your spouse have assumed legal responsibility and control. In no event will the plan cover a child:

- Who is temporarily living in your home; or

- Who is placed in your home by a social service agency that retains control of the child; or
- Whose natural parent is in a position to exercise or share parental responsibility and control.

If you are eligible for coverage based on your employment with the University you may be covered under your own employment or you may be covered as a dependent. You may not be covered both as a dependent and as an employee.

If you and your spouse work for the University and you have children, only one of you may claim the children as covered dependents.

## ***Plan costs***

The University pays the majority of the cost of your coverage.

Your contribution will be made on a before-tax basis, which lowers the current amount of income tax you pay, unless you choose to contribute on an after-tax basis. For more details about how the before-tax feature works for you, refer to your Flexible Benefits Plan booklet.

Please note that when your contributions are on a before-tax basis, certain Internal Revenue Service restrictions prohibit enrollment changes during the year unless the changes are due to a family status change and you notify your Campus Benefits Representative within 31 days.

## ***When coverage begins***

Coverage begins on the date of hire or the benefit eligibility date provided you submit the form within 30 days of your date of hire or eligibility date.

If you change from part-time to full-time or from temporary to permanent status and become benefit eligible, you must enroll within 30 days of the date of your change in status.

If you are not actively at work on the date your coverage would normally begin, the coverage will not be effective until you return to full-time active employment unless you are not actively at work due to a health factor.

## ***When coverage begins for dependents***

Dependent coverage becomes effective on the date your personal coverage becomes effective, if you have completed and returned the plan enrollment form with each dependent's name and Social Security number listed within 30 days of the date of eligibility. If, after your coverage becomes effective, you acquire a new dependent – by marriage, for example – you have 31 days to obtain coverage by completing the appropriate enrollment form and returning it to your Campus Benefits Representative.

In the case of an adopted child or a child placed in your home for adoption, you also have 31 days to obtain coverage from the date the child is placed in your custody.

It is your responsibility to notify the University of the addition of a dependent or any changes in your family status. Contact your Campus Benefits Representative to obtain any necessary forms.

In instances where applications for enrollment are submitted subsequent to 31 days following the initial date of eligibility, three situations may apply.

1. When the dependent for whom coverage is requested is a newborn or an adopted child for whom a specific premium contribution is required (i.e. coverage for other children does not already exist) coverage will become effective on the date of the child's birth or placement for adoption and will continue for 31 days thereafter, **provided the employee makes written request to cover the child within 180 days of the date the child first became eligible for coverage.** In this situation, coverage will be provided during the first 31 days and will cease as of the 32<sup>nd</sup> day and will subsequently resume as of the date the employee's request was received within the 180 day period.

If the request for coverage is not received within the 180 day period, the employee may request coverage during the next subsequent enrollment change period and it will be provided for the first 31 days following birth or adoption as the case may be, and will resume as of the following January 1.

2. When the dependent for whom coverage requested is NOT a newborn or adopted child for whom a specific premium contribution is required (i.e. coverage for other children does not already exist), coverage will become effective on the date a properly completed enrollment form (including proof of relationship) is submitted to your Campus Benefits Representative provided it is done so within 180 days from the date the child was first eligible. If the enrollment form is submitted after 180 days, coverage will not become effective until the following January 1.
3. If a specific premium is not required for coverage (i.e. coverage already exists for other eligible dependent children), coverage will be made effective on the date the child first became eligible for coverage. However, before claims can be paid, a properly completed enrollment form (including proof of relationship) must be submitted to your Campus Benefits Representative.

UM pays a portion of medical premiums for eligible dependent children who are enrolled for coverage under these programs.

The level of premium subsidy is limited to ten dependent children. Employees will be required to pay the full premium cost for each child that is enrolled beyond the maximum of ten.

Employees who have coverage for over ten children as of December 31, 2001 will continue to receive premium support for all children covered as of that date. Any new children, over the maximum of ten, who are enrolled on or after January 1, 2002 will require payment of the entire premium by the employee.

## ***Coverage of newborn children***

A newborn child will be covered from the date of birth only if you enroll the newborn within 31 days after birth. This enrollment must be submitted to your campus benefit representative at the University of Missouri.

## ***Changing your coverage — qualifying family/ employment status changes***

You may change your coverage level (including beginning or ending coverage or adding or dropping dependents) during the plan year only if you have a qualifying family/employment status change. However, you may not change your program option.

Qualifying family/employment status changes are limited to:

- marriage, divorce, legal separation or annulment
- death of spouse

- a change in the number of dependent children as a result of birth, death, adoption or placement of a child for adoption or a child ceasing to be eligible or becoming eligible as described on page 3
- the termination or commencement of employment of your spouse, a strike, a lockout or an unpaid leave of absence
- receipt by the University of a valid Notice of Order to Enroll under Missouri law
- a change in entitlement to Medicare or Medicaid for you, your spouse or a dependent child
- a significant change in health coverage provided by your spouse's employer that affects you or your spouse
- a leave of absence under the Family and Medical Leave Act of 1993 (FMLA).

If any of these qualifying family/employment status changes occur, you may change your level of coverage provided the change is consistent with the status change itself. Contact your Campus Benefits Representative to obtain the appropriate form, which must be completed and returned within 31 days of the date of the status change. After that, changes can be made only during the annual enrollment change period, except as required by the Health Insurance Portability and Accountability Act (HIPAA), described later in this section.

Benefit changes, when made within 31 days as described above, will be effective on the date of the event.

If you relocate and are eligible for different medical options in your new location, you may change your program option (but not your coverage level) subject to the 31-day requirement described above.

Under the Health Insurance Portability and Accountability Act, you or an eligible dependent may also enroll for coverage if:

- you or an eligible dependent declined coverage under the University plan because you had other coverage, and
- the other coverage ends, and
- you contact your Campus Benefits Representative and complete an enrollment form and provide written proof that the other coverage ended for the individual involved within 31 days after this event occurs.

This is called a *special enrollment period*. Coverage will be effective on the first day of the month following the date your enrollment form is received by your Campus Benefits Representative.

## ***Changing medical programs***

Changes can only be made during the Annual Enrollment Change Period unless you have a qualified family status change. Changes made due to a qualified family status change must be made within 31 days of the event.

You and your dependents must be covered by the same medical coverage program.

# *Important Information*

## *Benefit Summaries & Service Area Maps*

Please refer to the booklet titled Benefit Summary for Full Time Faculty & Staff for service area maps that can be used to identify the options available in your geographic area. This booklet will also provide you with a summary of all deductible, copayment, coinsurance and benefit maximum information.

## *Coordination of benefits*

Like most group health plans, your medical benefit plan includes a coordination of benefits (COB) provision. If you or any of your dependents are eligible to receive benefits under more than one group plan, your benefits will be coordinated so the total amount paid by all plans will not exceed 100% of the allowable expenses incurred.

Under COB, one plan is considered “primary” and the other “secondary.” The plan that is primary pays first and usually pays full regular benefits. The primary plan is determined as follows:

- If a plan covers the patient as an employee, that plan is primary.
- If the patient is a dependent child whose parents are not divorced or separated, the plan of the parent whose birthday is earlier in the calendar year is primary.
- If the patient is a dependent child whose parents are divorced or separated, the following rules apply:
  - A plan that covers a child as a dependent of a parent who by court decree must provide health coverage is primary.
  - When there is no such court decree, then the plan of the parent who has custody of the child is primary. (The plan of the custodial parent’s spouse is secondary and the plan of the other natural parent is third.)
- If a plan covers a person as an active employee, that plan is primary and any plan that covers the person as a retired or former employee is secondary. If a plan covers a person as a dependent of an active employee, that plan is primary and a plan that covers the person as a dependent of a retired or former employee is secondary.
- If a plan covers a person because of federal continuation-of-coverage laws, that plan is secondary to a plan that covers the person on any other basis.
- If none of the above rules apply, the plan that has covered the patient for the longer period of time usually will be primary.

After the primary plan pays its benefits, the secondary plan will, in most cases, pay the balance of your eligible medical expenses.

To ensure you receive the benefits to which you are entitled under both plans, it is important to submit your claims properly. For example, when you file a claim for your spouse, be sure to file under his or her plan first. After you have received payment from your spouse’s plan, you can then submit a claim for payment to your plan. When you submit a claim to the second plan, be sure to include the Explanation of Benefits Summary from the

primary plan, as well as another copy of the bill. Remember, if you coordinate your benefits correctly, you will receive payment faster and still have the advantage of coordinated coverage under both plans.

## **Coordination with Medicare**

The University assumes all *active* employees and their dependents will be provided with primary coverage under this plan, with secondary coverage provided by Medicare (if enrolled for Medicare). Before retirement, submit your claims to the University's plan first, then to Medicare.

Once you retire or become disabled and receive benefits under the University's Long Term Disability Plan, the University will coordinate your benefits with Medicare. Medicare will be primary and this plan will provide secondary coverage. This plan will also be secondary to Medicare for any individual who is eligible for Medicare due to end stage renal disease after the first 18 months of Medicare eligibility. Claims should be submitted first to Medicare, then to the University's plan.

## ***When medical coverage ends***

Your medical coverage will end on the earliest of the following dates:

- Coverage will end on the last day of month of the employment termination.
- When you are no longer eligible for coverage.
- When you cease making the required health plan contribution.
- When the University discontinues the plan.

If your contributions are paid on a before-tax basis, you may not discontinue dependent coverage during the year (when you continue to be eligible for coverage) unless the change is in connection with a qualifying family/employment status change.

## **Certificate of creditable coverage**

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), the University will provide a written certificate of creditable coverage automatically when your coverage under a health plan ends or when your COBRA coverage ends. You may request a certificate of creditable coverage from your Campus Benefits Representative at any time within the 24-month period after your coverage ends.

You may need to provide this certificate of creditable coverage as proof of prior medical coverage if:

- You become eligible for another employer's medical plan within 63 days of the date your University coverage ends, and
- The new plan has a pre-existing conditions exclusion period that may apply to you.
- 

## **Continued medical coverage during a leave of absence**

Your medical coverage may be continued while you are on a leave of absence, protected by the Family and Medical Leave Act of 1993 (FMLA), provided you continue to pay any required contributions. If your contributions are more than 30 days late, your coverage under the plan will end. However, upon your return to

work from a leave approved under the FMLA, you will be entitled to have your medical coverage reinstated. If you fail to return to work following the leave, you may be required to pay back the University for the cost of providing medical coverage during your leave. However, you will not be required to repay the University if the reason you failed to return is due to a serious health condition or other circumstance beyond your control, as provided by law.

Your medical coverage may be continued during a leave of absence for other reasons, according to University policy. Contact your Campus Benefits Representative for more information.

## **Continuation of medical coverage after retirement**

If you are eligible to receive medical benefits under the University Retirement Plan or would be eligible if you were not covered under Civil Service Retirement, Federal Employee Retirement or the Missouri State Retirement Plans, you and your eligible dependents may continue your medical coverage under the plan available to retirees.

The University will advise you concerning the method and amount of any required contributions for medical coverage.

## **Continuation of medical coverage for dependents after the death of an employee**

If you die while actively employed by the University and after becoming vested in the University Retirement Plan (having completed at least five years of creditable service), or if you would have been vested if you were covered by the University Retirement Plan instead of the Civil Service Plan, Federal Employee Retirement Plan or the Missouri State Retirement Plan, your eligible spouse may continue medical coverage after your death under the plan available to retirees. In addition, the continuation of medical coverage is available for your children, but only when spouse coverage is also continued. The continuation of medical coverage under this provision is subject to the payment of monthly contributions by your spouse. An eligible spouse, for the purposes of this provision, is the spouse to whom you were married on the date of your death, provided you had been married to this spouse for at least one year preceding your death. Eligible children are described on page 3.

If you die after retirement from the University, your eligible spouse may continue medical coverage after your death, as described above, including coverage for your children. It is important to note that the medical coverage for the surviving spouse of a retiree is available only to the person to whom the retiree was married on the day preceding the date of retirement. The level of premiums will be somewhat different for widowed spouses than that provided for eligible employees, and the widowed spouse will be responsible for a larger portion of the cost.

No continued medical coverage is available for children unless there is a surviving spouse who is also covered.

Enrollment for continued medical coverage must be made within 31 days after the employee death.

Continued medical coverage will terminate for any dependent on the earliest of the following dates:

- The date the individual no longer meets this plan's definition of an eligible dependent.
- The date all dependent coverage is discontinued under this plan with respect to your class of employees.
- The end of the period for which the required contributions have been made.

## ***Continuation of medical plan coverage (COBRA)***

Federal law requires the plan to offer covered employees and dependents the opportunity to continue medical coverage when it ends for certain specified reasons. This law is called the Consolidated Omnibus Budget Reconciliation Act of 1985 — COBRA. The following provisions outline the requirements for continued medical coverage in accordance with the law. These provisions apply only to the extent that the required period of continued medical coverage has not already been provided under other plan provisions.

### **Eligibility for continued medical coverage**

An employee and his or her covered dependents may continue medical coverage for up to 18 months if coverage ends because of either a reduction in the number of hours worked or termination of employment for any reason other than gross misconduct.

Dependents may continue their medical coverage under the group plan for up to 36 months if their coverage ends for any of the following reasons:

- Divorce or legal separation from the employee.
- The death of the employee.
- The dependent child reaches the limiting age or otherwise ceases to qualify as a dependent under the plan.

These periods of continued medical coverage begin on the date of loss of coverage following the event; for instance, the first of the month following the date you leave the University or the date a dependent becomes ineligible.

In no event will more than a total of 36 months of continued medical coverage be provided to any individual, even if more than one of the above events occurs.

Continued medical coverage ends automatically if any of the following occurs:

- The cost of continued coverage is not paid on or before the date it is due.
- An individual becomes covered under another group plan unless coverage under that other plan is limited due to the individual's pre-existing condition.
- An individual becomes entitled to Medicare.
- The plan terminates for all employees.
- The applicable maximum coverage period ends.

### **Application for continued medical coverage**

Once you notify your Campus Benefits Representative that one of these events has happened, you will be sent an election form explaining the conditions that apply to continued medical coverage.

However, in the event you become divorced or legally separated, or when your dependent child no longer qualifies as a covered dependent under the plan, you or your covered spouse or your covered child must notify

your Campus Benefits Representative within 60 days. If you fail to do this, your dependent's rights to continued medical coverage will be forfeited.

Continued medical coverage is not automatic. You must submit the completed election form within 60 days from the later of the following dates:

- The date you cease to be eligible under the group plan.
- The date you receive the election form.

## **Cost of continued medical coverage**

Any person who elects to continue medical coverage under the plan must pay on a monthly basis the total of that coverage plus any additional amount permitted by law. Your first payment for continued medical coverage must be made within 45 days of the date you sign the election form. Your payment must be sufficient to pay the applicable costs retroactive to the day following the event which caused coverage to end.

## **Benefits under continued medical coverage**

Continued coverage will be exactly the same medical coverage you or your dependent would have been entitled to if your employment or his or her dependent status had not changed. Any future changes in the benefits or cost of coverage for the plan also will apply to you. A dependent child you acquire while covered by these provisions will also be entitled to continued medical coverage. The conversion privilege is available when the maximum period of continued medical coverage ends.

## **Extension of maximum coverage period**

**Disabled individuals** — An exception applies if an employee or a dependent is determined to be totally disabled during the first 60 days of continued medical coverage due to reduction in hours worked or termination of employment. The maximum coverage period for the disabled individual will be 29 months, rather than 18 months. To be eligible for the extended period, the disabled individual must meet the definition of disability under the Social Security Act and notify the University during the first 18 months of continued coverage and within 60 days after the date of determination of disability has been made by Social Security. (The disabled individual is required to notify the University within 30 days after any final determination by the Social Security Administration that the individual is no longer disabled.)

**Divorced or widowed spouses at least age 55** — Medical coverage can continue beyond the COBRA period if the continuation coverage under the plan expires when a divorced or widowed spouse is at least age 55. Coverage can continue for the spouse and eligible dependents until the spouse reaches age 65.

**Dependents of an employee entitled to Medicare** – If an employee becomes entitled to Medicare, the maximum coverage period for dependents will not end until at least 36 months after the date on which the employee became entitled to Medicare.

## **Conversion of medical benefits upon termination**

The plan permits certain individuals whose medical coverage has terminated to convert to an individual medical policy without medical examination. The privilege is available to you and your dependents if your employment terminates or if you cease to be eligible. Also, even though your own coverage may continue, your dependents can apply if they cease to meet the plan's definition of a dependent. However, no one who has been covered under the plan for fewer than three months may convert.

Application must be made for the individual policy within 31 days after coverage terminates. The claims administrator will arrange for the issuance of the individual policy, provided it does not result in over-insurance and does not violate any applicable laws.

## ***Filing a claim for benefits***

No matter what medical plan you choose — the POS Program, the Catastrophic Program or an HMO alternative — always have your identification card with you when you visit your doctor or other health care provider.

If you elect the POS Program you do not have to file a claim for network care. The provider will do that for you.

For non-network care under the POS Program and all expenses under the Catastrophic Program, you must file a claim.

You may access forms online through the Benefits web site or your Campus Benefits Representative has a supply of all forms required to file medical claims. The completed claim forms should be submitted to the claims administrator at the address shown on the form. The instructions on the form should be followed carefully. To speed the processing of your claim, be sure all questions are answered fully.

By completing your claim form accurately, you save time and unnecessary paperwork, and the health plan saves on administrative costs. The next time you file a claim, remember to:

- Make sure your expenses have reached your deductible.
- Avoid submitting the same claim twice.
- File your spouse's claim under his or her plan first.
- Use a separate claim form for each family member.
- Provide your medical card ID number or Social Security number.
- Submit copies of completely itemized bills showing the type of illness or injury.

Claims should be submitted promptly (**no later than 18 months following the date the service is rendered under the Catastrophic Program and no later than 12 months under UM Choice Plus POS Program**). Return completed forms, correspondence and all bills according to the instructions provided on the forms.

## **How benefits will be paid**

Benefits will be paid as soon as the necessary written proof to support the claim is received. Benefits for network providers under the POS Program will automatically be paid to the provider. All other benefits are payable to you directly or to the provider of services if you have assigned benefits.

## **Non-network claim discounts or write-offs**

No participant is entitled to benefits for any claims which are reduced by the provider after benefit payments have been paid by a University plan. All discounts or forgiven charges must be applied before claims are submitted to the University plan for payment.

## Claim questions

If any portion of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, there are several things that you can do to appeal the decision. Most of your questions can be answered quickly and efficiently by either calling or writing the claims administrator. The address and telephone number are shown on your ID card and on claim forms.

If any part of your claim is denied, you will be notified in writing. The notice will include:

- The specific reason for denial.
- The specific references to pertinent program provisions on which the denial is based.
- A description of any additional material or information necessary for you to substantiate your claim and an explanation of why such material is needed.

The claims administrator will respond to claims promptly. However, if you do not receive a response within 90 days, allowing reasonable time for mailing, you may assume your claim has been denied and proceed to the claim review stage.

Within 60 days after receiving notice that your claim has been denied, you or your authorized representative may submit a written request for review to the claims administrator.

In your request, state the reasons you believe the claims denial was improper, and submit any additional information, material or comments you consider appropriate. You may review any pertinent documents related to the claim.

The claims administrator's decision will be in writing and will include specific references to the pertinent plan provisions on which it is based.

# *University of Missouri Choice Plus Point of Service Program*

## *How the UM Choice Plus POS Program works*

### **Two choices for treatment**

Each time you need medical treatment, you can choose how to receive your care. You may be treated by network providers or non-network providers. However, you will receive the highest level of benefits for services that are received from network providers. With the POS Choice Plus Program, you do *not* select a primary care physician (PCP).

### **The network**

The physicians and hospitals that are providers in the network have contracted with United Health Care to be a part of the UM Choice Plus POS Program and have agreed to charge negotiated rates for specific services. United Health Care oversees selection and monitors the credentials of the physicians and hospitals who join the network. These providers join the network to gain access to a greater number of patients and to get the advantage of a faster and easier claim payment system. In a competitive health care industry, most providers want less paperwork and higher patient volumes to cover overhead costs.

### **Network benefits**

Network benefits are provided for care you receive from any physician, hospital or other medical care facility participating in the network. The network is a national network with network providers located in a majority of locations around the country.

You pay a copay for most physician office visits in the network. The copay is a flat dollar amount you pay at the time you receive treatment.

- You do not have to precertify hospitalizations when your hospitalization and/or surgery are coordinated by a network physician.
- To receive network level benefits, you are responsible for making certain services are provided by a network physician and facility
- You must meet an annual deductible for services not subject to a copay before the plan will cover the cost of the service.
- Benefits for non-network provider services in connection with a life-threatening emergency while traveling are covered at the network level.
- There are no claim forms to fill out for network treatment.

### **Emergency care**

In a life-threatening emergency, go to the nearest hospital. Network benefits will apply to your care. A life-threatening emergency is an illness or injury that without immediate medical care could put your life in danger or cause serious harm to your bodily functions. Examples include heart attack, stroke, extreme bleeding, loss of consciousness, convulsions, severe or multiple injuries, severe auto accident, loss of breathing and poisoning.

Network benefits continue to apply to expenses related to the emergency if you inform United Health Care of the emergency within 24 hours or as soon as reasonably possible after any emergency hospital admission and you receive approval for continued care.

If you visit a hospital emergency room and the situation is urgent but not life-threatening, you will receive non-network benefits for the emergency room charge, unless you are directed to the emergency room by a network physician. However, any care received during normal physician's office hours will not be covered in the emergency room, except in the case of life-threatening emergency or when you are directed to the emergency room by a network physician. In a less serious situation, contact a network physician before you are treated. If a network physician directs you to the emergency room, you will receive network benefits.

If you are outside your network area and need care for a life-threatening emergency, seek care immediately. It will be covered at the network benefit level. Be sure to have your identification card with you. You will need it to prove that you have coverage. You must call United Health Care the next business day or as soon as possible to continue to receive network benefits. If you do not call, or approval for follow-up care is not given, non-network benefits apply.

If you must pay for the medical treatment you receive, be sure to get a copy of the emergency room report, all bills, and a receipt for your payment. Ask the doctor and hospital to send copies of all bills to United Health Care.

Remember, for you to receive network benefits, your condition must be a life-threatening emergency, unless you are directed to the emergency room by a network physician.

If you are outside your network area and need non-emergency care, you must return to the network area and see a network physician, or non-network benefits will apply.

## **Urgent care centers**

Urgent care centers may be available in your network area for emergencies that are not life-threatening but require immediate medical attention. Examples of urgent conditions include high fever, a cut that needs stitches, severe vomiting, sprains and intense pain.

If you receive care from a network urgent care center, you pay a copay as shown in the Benefit Summary.

If you go to a non-network urgent care center, non-network benefits will apply.

## **If you have dependents who live outside your network area**

If you have an enrolled dependent who is living outside your network area and the dependent needs emergency care, he or she should first seek medical care. Emergency care is covered at network benefit levels. If the dependent seeks non-emergency care outside the network area, non-network benefits will apply.

## **Non-network benefits**

Non-network benefits are paid for care you receive from physicians, hospitals and other health care facilities that do not participate in the United Health Care Choice Plus network. Exceptions apply to life-threatening emergencies, as described under *Network benefits*.

The amount the plan pays for non-network care is shown in the *Benefits Summary*.

## ***Other Important Information***

Information in this section applies to the UM Choice Plus POS Program.

### ***Reasonable and customary charges***

Payments for your covered non-network medical expenses (UM Choice Plus POS Program only) are based on reasonable and customary charges (R & C). The R & C charge is determined for the same or a similar service in a geographic area. Any portion of the eligible expense that is above the R & C charge will not be reimbursed by the plan. In addition, expenses above the R & C charge do not count toward your deductible or out-of-pocket limit.

Network providers agree to accept pre-negotiated, fixed fees for their services. When you receive care from network providers, you will pay only your copayments and coinsurance portion for covered services.

### ***Covered medical services***

You can receive benefits only for charges incurred by a covered individual for the services and supplies listed as eligible expenses in the section called *Eligible Expenses and Exclusions* on page 34. These services and supplies must be prescribed or performed by a physician or other qualified medical provider for the medically necessary treatment of a non-occupational sickness or injury and provided based on generally accepted medical practice.

### ***Annual deductible***

Your deductible is the initial amount of covered medical expenses that you pay each calendar year before the plan begins paying benefits.

The annual deductible for network care and non-network care may not be combined.

#### **For network care**

There is a \$250 calendar-year deductible that you must pay before you can receive benefits with the exception of any network care subject to copayment, such as physician's office visits, inpatient hospital service, physical therapy, speech therapy or occupational therapy.

If two or more covered members of your family are injured in the same accident, only one individual deductible is required for all medical charges related to that accident (if your deductible has not already been satisfied).

Charges incurred for prescription drugs do not apply to your annual non-network deductible

#### **For non-network care**

For all non-network care, you or each covered family member must pay a separate deductible before any non-network benefits are paid in any calendar year. The deductible amount is shown in the Benefit Summary.

However, the following exceptions apply:

- You will pay no more than the amount shown in the Benefit Summary toward the deductible for all of your covered family members' expenses in one calendar year.

- If two or more covered members of your family are injured in the same accident, only one individual deductible is required for all medical charges related to that accident (if your deductible has not already been satisfied).
- There is no deductible required for preventive care.

Charges incurred for network care, prescription drugs or mental health and chemical dependency treatment do not apply to your annual non-network deductible.

## ***Copays***

For certain types of care, you will pay an up-front charge. This is called a copay.

The copay amounts that apply to each type of care are shown in the Benefit Plan summaries. However, the following exceptions apply:

- You will pay no more than one hospital copay in a 60-day period for any subsequent admission for the same diagnosis.
- The emergency room copay is waived if you are admitted to the hospital from the emergency room.

Copays do not apply toward your deductible or your out-of-pocket limit.

## ***Coinsurance***

For some eligible expenses, you pay a percentage of the cost and the plan pays the remainder (after the deductible and copay, if applicable) until the out-of-pocket limit is reached. This is called coinsurance. The coinsurance you pay does apply toward your deductible.

The *University of Missouri Choice Plus POS Program* Benefit Summary shows the types of expenses subject to coinsurance.

## ***Out-of-pocket limit***

The out-of-pocket limit places a cap on the amount you will pay for eligible expenses in one calendar year. For some types of eligible expenses, you pay an annual deductible and 20% of the cost. Once your share of these expenses for one person in your family reaches the out-of-pocket limit, the plan pays 100% of all remaining covered medical expenses for that calendar year for that covered person. The amount of your out-of-pocket limit is shown on the *University of Missouri Choice Plus POS Program* Benefit Summary.

If the out-of-pocket expenses incurred by all of your covered family members combined reach the family out-of-pocket limit in one calendar year, the plan pays 100% of any additional expenses incurred by any covered family member for the balance of that calendar year. The amount of your family out-of-pocket limit is shown on the *University of Missouri Choice Plus POS Program* Benefit Summary.

The network and non-network out-of-pocket amounts may not be combined.

The following expenses do *not* count toward the out-of-pocket limit and are *not* paid at 100% after the out-of-pocket limit is satisfied:

- Copay amounts you pay at the time of service for hospital care, urgent care, emergency room care and office visits.
- Prescription drug expenses. For more information on prescription drug benefits, see page 24.
- Expenses that are not covered by the plan, such as charges above reasonable and customary, penalties for failure to precertify hospitalization or surgery under the Utilization Management program.

## ***Maximum plan benefit***

The most the plan will pay for all network and non-network expenses incurred by a covered person in a lifetime is shown in the Benefit Summary. This limit applies to the combined benefits paid by the POS Program, the Catastrophic Program and any other programs previously sponsored by the University.

The limit does not apply any HMO's.

## ***Utilization management***

Utilization Management, provided by United Health Care, is a program that reviews hospital admissions and surgeries (inpatient and outpatient) both in advance and during treatment. This program reviews the utilization of health care services to help assure employees and the medical plan are receiving appropriate and necessary medical care and avoiding unnecessary or questionable services. *You must follow the Utilization Management procedures or you must pay a penalty as shown in the Benefit Summary in addition to any copays or deductibles.*

When your hospitalization or surgery is supervised by a network physician, he or she will handle the precertification procedures for you. However, for non-network care, you are responsible for obtaining precertification. This would include making sure that even if you have a network physician, that the facility is also in the network.

Utilization Management is managed and administered by an experienced staff of health care professionals at United Health Care who will work with you, your doctor and the hospital in the management and delivery of health care services.

## **Precertification before hospitalization or surgery (including outpatient surgery)**

If a network physician recommends hospitalization or surgery, follow these steps:

- Prior to admission, you or your doctor must call Care Coordination to initiate the notification process. The telephone number is shown on your medical plan ID card. Basic information about you (the patient) and the condition causing the need for hospitalization or surgery must be provided. Any additional information will be obtained from your doctor.
- If hospitalization or surgery is needed for urgent or emergency care, you or your doctor must call Care Coordination within 24 hours of receiving that care or as soon as reasonably possible.
- The proposed treatment will then be reviewed according to widely accepted standards and criteria for medical admissions of the same type, taking into consideration all relevant facts and circumstances applicable to your specific case. You and your doctor will then be notified verbally and in writing as to whether the confinement meets the criteria. Since this process occurs prior to the admission, you and your doctor will have the opportunity to question or appeal the certification prior to admission to the hospital if

there is any disagreement. It is especially important that Utilization Management be contacted seven days prior to non-emergency hospitalization or surgery so that your treatment plan can be reviewed.

- Once a hospital confinement is certified, whether it be on an emergency or non-emergency basis, a registered nurse will perform regular reviews of your medical progress. This will be accomplished through consultations with your doctors and nurses and, with your consent, through the review of your medical records. A signed release may be needed in some circumstances to authorize the nurse to review the medical records. This concurrent review is to help assure that you receive appropriate medical services.
- Another benefit of this concurrent review is that it allows Care Coordination to identify cases that require extended hospitalization and use of the Discharge Planning Program. Discharge planning involves the exploration of opportunities that would allow discharge from the hospital only when it is prudent. Care Coordination will coordinate discharge planning with your doctors, hospital nurses and social service organizations. This is to help see that a smooth and safe transition from the hospital to the home or other health care facility occurs if, for example, extended care or home health services are required.

### **Precertification penalty**

If precertification is not received before a hospital admission or surgery (inpatient or outpatient), you will pay an additional \$500 of the covered charges. This penalty does not apply if your hospitalization or surgery is recommended by a network physician, if you are enrolled in the POS Choice Plus Program. The penalty will not count toward your deductible, hospital copay or out-of-pocket limit.

### ***Maternity and newborn care***

Maternity expenses for an employee or an employee's spouse are eligible for reimbursement like expenses for an illness. All the provisions and limitations of the plan also apply to pregnancy, except that in accordance with federal law, hospital charges in connection with a covered admission for childbirth will be provided for a minimum of 48 hours in connection with normal delivery and for 96 hours in connection with a cesarean section.

All maternity care must be coordinated by your network OB/GYN to be eligible for network benefits. For each prenatal office visit to a network provider, the only charge you incur is the first office visit copay.

For non-network care, Utilization Management should be contacted to initiate the certification process after the mother's sixth month of pregnancy. Then, when the admission actually occurs, they should be notified again.

Elective abortions are not covered. Also, the UM Choice Plus POS Program and Catastrophic Program does not cover pregnancy expenses of a dependent child.

### **Newborn care**

It is your responsibility to enroll your newborn child by contacting your Campus Benefits Representative.

The plan automatically covers the routine hospital nursery care of newborn children if the mother is covered by the plan and the newborn is enrolled within 31 days of birth. No separate deductible or hospital copay applies to expenses incurred by the newborn while in the hospital following birth.

## ***Prescription drug benefits***

The prescription drug program offers you prescription drug coverage for most drugs and medicines prescribed by a physician and dispensed by a licensed pharmacist, including syringes needed for administration of a drug, through Express Scripts, Inc. (ESI). ESI provides managed prescription drug services through an extensive national network of retail pharmacies as well as a mail-order program.

Short-term therapy drugs are medications commonly prescribed for illnesses like flu and strep throat, but may include the initial prescription for a new, long-term medication. You purchase these medications at a local pharmacy.

Maintenance/long-term therapy drugs are those drugs usually taken on a regular basis for chronic conditions such as high blood pressure, arthritis, heart problems and diabetes. Maintenance/long-term therapy drugs may be purchased either at your local pharmacy or through mail-order service.

Maintenance drugs are subject to a Step Therapy process requiring the use of first-step drugs (generally generics) before allowing the use of a second-step (formulary brand name) drugs. If the first step drug does not work and/or your physician determines that you need a brand-name drug for medical reasons, your physician will need to request an override to obtain approval for the second-step drug. This does not apply to any drug used by a participant in a course of treatment in effect on December 31, 2005.

Mandatory generic substitution applies to all prescription drugs. This means that if there is a generic version of a brand drug which is prescribed, only the cost of the generic drug will be considered under the prescription drug program *unless* prior authorization is obtained from Express Scripts for you to receive the brand drug.

### **Short-term therapy drugs — retail pharmacy**

For retail prescription drugs, you pay a separate calendar-year drug deductible as shown in the Benefit Summary for you and each family member. After the drug deductible is met, your benefits are paid based on whether or not your prescription is filled at a participating pharmacy. The drug deductible does not count toward any other deductible or the medical out-of-pocket limit.

- If your prescription is filled at a *participating ESI network pharmacy*, then you pay a portion of the cost as shown in the Benefit Summary after you have met your deductible. No claim form is required when you use your prescription drug identification card. Up to a 30-day supply will be provided when a prescription is filled.

If you request a brand name drug and your physician has prescribed a generic, you will pay the applicable copayment plus the entire difference between the cost of the brand name drug and the generic drug.

Also, ESI maintains a formulary, which is a list of commonly prescribed generic and brand-name drugs chosen for their quality and cost-effectiveness. The formulary is available from ESI.

- If your prescription is filled somewhere *other than a participating network pharmacy*, then you must pay the difference between the pharmacy's charge and the price an ESI pharmacy would charge for the same drug based on the discount prices negotiated by ESI, in addition to the deductible and the greater of \$30 or 50% of the covered amount. You must submit a claim form to receive reimbursement.

### **Long-term therapy drugs — mail order**

Maintenance/long-term drugs are those drugs usually taken on a regular basis. By ordering maintenance/long-term drugs through the mail, you save time and money. Your Cost is shown in the Benefit Summary. For each

copay, you may receive up to a 90-day supply of the drug. No deductible is required under the mail-order service program. And, you don't have to suffer through long lines at the pharmacy because your prescriptions are mailed directly to your home.

To receive your maintenance/long-term drugs from ESI through the mail, follow these steps:

- Complete a patient profile/order form.
- Attach the original prescription(s).
- Mail both forms, along with your payment, to ESI.

If you request a brand name drug and your physician has prescribed a generic, you will pay the applicable copayment plus the entire difference between the cost of the brand name drug and the generic drug.

Each order is reviewed, dispensed, and verified by a registered pharmacist at ESI. Throughout the filling of your order, it is checked several times to ensure that the correct quantity, daily dosage and strength of medication is sent to you.

Your order will normally be shipped within 10 working days after receipt by ESI to the address you indicate on the order form. To ensure security, the package will not indicate that drugs are inside.

If your prescription allows refills, the number of refills remaining will be indicated, and refill stickers will be provided for easy reordering. For a patient profile/order form, call ESI patient services at 1-800-955-1201 or contact your Campus Benefits Representative.

### **Specialty drugs —**

Specialty drugs are high cost drugs used for treatment of conditions such as multiple sclerosis, arthritis, cancer, asthma, growth hormone deficiencies and other conditions. These drugs require a level of intervention and monitoring (beyond what is needed for a normal maintenance medication) to ensure quality outcomes.

Specialty drugs must be obtained through CuraScript after the first fill. If these drugs are obtained through your physician or a medical facility, they will not be covered. To get a prescription from CuraScript or for additional information about their services, call 1-866-413-4135.

### **Prescription drug out-of-pocket limit**

The out-of-pocket limit places a cap on the amount you will pay for eligible prescription drug expenses in one calendar year. If you have satisfied your annual deductible, and your share of prescription drug copayments and coinsurance for one person in your family reaches the out-of-pocket limit, the plan pays 100% of all remaining covered prescription drug expenses for that calendar year for that covered person. The amount of your out-of-pocket limit is shown in the benefit summary.

### **Drugs not included for coverage**

The following drugs and supplies are not covered:

- Non-legend drugs other than insulin.
- Therapeutic devices/appliances.
- Drugs intended for use in a physician's office or other than at home.

- Investigational or experimental drugs including compounded medications for non-medical substitution.
- Prescriptions entitled under Workers' Compensation and/or other municipal, state or federal programs.
- Smoking cessation productions.
- Drugs for any cosmetic purpose.
- Over-the-counter drugs and medicines.
- Drugs used in the treatment of sexual dysfunction or gender identity.
- Drugs used for the treatment of infertility or for ovulation stimulation

## ***Mental Health and Chemical dependency benefits under the University of Missouri Choice Plus POS Program***

Mental health and chemical dependency benefits are provided through United Behavioral Health (UBH). The UBH network consists of a wide range of professionals including psychiatrists, psychologists, psychiatric social workers, and professional counselors representing a variety of special care needs. The plan will pay for eligible mental health and chemical dependency charges as specified in the benefit summary.

- When you need mental health or chemical dependency care, you first must call UBH's toll-free clinical referral line at 1-800-851-2054 to pre-authorize.
- Benefits for emergency care are covered if UBH is contacted within 24 hours of the emergency treatment.

### **Exclusions and Limitations**

Charges for the following mental health or chemical dependency treatment are not covered:

- treatment rendered in connection with mental retardation;
- conditions not subject to favorable modification according to generally accepted standards of psychiatric care;
- relationship, marriage, academic and other counseling when not attributable to a mental disorder;
- treatment for pain with physiological origins, unless United Behavioral Health determines such pain has psychological or psychosomatic components;
- psychiatric or psychological examinations, testing, or treatments for purposes of school evaluations; marriage; adoptions; medical research; obtaining or maintaining employment, a license, insurance or other official document; or solely relating to judicial or administrative proceedings;
- service and treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless authorized by United Behavioral Health as Medically Necessary and Appropriate as Mental Health and Chemical Dependency services;
- treatment out of the network service area;
- experimental, investigational, controversial or unproven services, treatments, devices, or pharmacological regimens as determined by United Behavioral Health including services utilizing methadone treatment, L.A.A.M., Cyclazocine or their equivalents;

- prescription medications, speech therapy, radiology fees and laboratory fees for outpatient treatment;
- services for Participants who are consciously and deliberately noncompliant with United Behavioral Health recommended treatment, when such noncompliance is not a direct result of a psychiatric illness;
- transportation by ambulance or other means, except for inter-hospital transportation authorized by United Behavioral Health.

# *The Catastrophic Program*

## *Catastrophic Program Benefit Summary*

Please refer to the booklet titled Benefit Summary for Full Time Faculty & Staff for the benefit summary of the Catastrophic Program. The benefit summary shows deductible, copayment, coinsurance and benefit maximum information.

## *How the Catastrophic Program works*

For some individuals, the Catastrophic Program is the solution to their health care needs. Because this plan has higher out-of-pocket limits and higher deductibles, it is often the choice for individuals who require less health care coverage because they are covered under another health care plan or can afford the extra out-of-pocket costs. If you elect the Catastrophic Program option, the Program pays the same benefits for care from any qualified health care provider.

## *Reasonable and customary charges*

Payments for your covered medical expenses are based on reasonable and customary charges. The reasonable and customary charge is determined for the same or a similar service in a geographic area. Any portion of the eligible expense that is above the reasonable and customary charge will not be reimbursed by the program. In addition, expenses above the reasonable and customary charge do not count toward your deductible or out-of-pocket limit.

## *Covered medical services*

You can receive benefits only for charges incurred by a covered individual for the services and supplies listed as eligible expenses in the section called *Eligible Expenses and Exclusions* on page 34. These services and supplies must be prescribed or performed by a physician or other qualified medical provider for the medically necessary treatment of a non-occupational sickness or injury and provided based on generally accepted medical practice.

## *The annual deductible*

Your deductible is the initial amount of covered medical expenses that you pay each calendar year before the program will pay any benefits. The deductible is shown in the Benefit Summary.

## **Family deductible limit**

If the expenses applied to the deductible for all of your covered family members combined reach the Family Deductible limit shown in the Benefit Summary in one calendar year, no additional deductible will be required for any of your other covered family members in that year.

## **Common accident deductible**

If two or more covered members of your family are injured in the same accident, only one individual deductible is required for all medical charges related to that accident (if your deductible has not already been satisfied).

## ***Copays***

You pay a copay per confinement as shown in the Benefit Summary for hospital admissions, in addition to the annual deductible. This copay does not count toward your annual deductible or your out-of-pocket limit.

However, you will pay no more than one hospital copay in a 60-day period for any subsequent admission for the same diagnosis.

## ***Coinsurance***

After you satisfy the annual deductible and the hospital copay, if applicable, the program pays 80% of eligible expenses until the out-of-pocket limit is reached. You pay the other 20%. This is called your coinsurance.

## ***Out-of-pocket limit***

The out-of-pocket limit places a cap on the amount you will pay for eligible expenses in one calendar year. For all eligible expenses, you pay an annual deductible and 20% of the cost. Once your share of these expenses for one person in your family reaches the out-of-pocket limit, the program pays 100% of all remaining covered medical expenses for that calendar year for that covered person.

If the out-of-pocket expenses incurred by all of your covered family members combined reach \$12,000 in one calendar year, the program pays 100% of any additional expenses incurred by any covered family member for the balance of that calendar year.

The following expenses do not count toward the out-of-pocket limit and are *not* paid at 100% after the out-of-pocket limit is satisfied:

- The hospital copay.
- Expenses that are not covered by the program, such as charges above reasonable and customary, or penalties for failure to precertify hospitalization or surgery under the Utilization Management program.

## ***Maximum program benefit***

The most the program will pay for all expenses incurred by a covered person in a lifetime is shown in the Benefit Summary. This limit applies to the combined benefits paid by the POS Program, the Catastrophic Program and any previous program sponsored by the University.

This limit does not apply to HMO Programs, which may have their own lifetime maximums.

## ***Utilization management***

Utilization Management, provided by Great West Life Insurance Company, is a program that reviews hospital admissions and surgeries (inpatient and outpatient), both in advance and during treatment. This program reviews the utilization of health care services to help assure employees and the medical plan that you are receiving appropriate and necessary medical care and avoiding unnecessary or questionable services. *You must follow the Utilization Management procedures or you must pay a penalty in addition to any copay or deductibles.*

Utilization Management is managed and administered by an experienced staff of health care professionals at Great West Life Insurance Company who will work with you, your doctor and the hospital in the management and delivery of health care services.

## **Precertification before hospitalization or surgery (including outpatient surgery)**

If a physician recommends hospitalization or surgery, follow these steps:

- Prior to admission, you or your doctor must call Utilization Management to initiate the precertification process. The telephone number for Utilization Management is shown on your medical plan ID card. Basic information about you (the patient) and the condition causing the need for hospitalization or surgery must be provided. Any additional information will be obtained from your doctor.
- If hospitalization or surgery is needed for urgent or emergency care, you or your doctor must call Utilization Management within 24 hours of receiving that care or as soon as reasonably possible.
- The proposed treatment will then be reviewed according to widely accepted standards and criteria for medical admissions of the same type, taking into consideration all relevant facts and circumstances applicable to your specific case. You and your doctor will then be notified verbally and in writing as to whether the confinement meets the criteria. Since this process occurs prior to the admission, you and your doctor will have the opportunity to question or appeal the certification prior to admission to the hospital if there is any disagreement. It is especially important that Utilization Management be contacted seven days prior to non-emergency hospitalization or surgery so that your treatment plan can be reviewed.
- Once a hospital confinement is certified, whether it be on an emergency or non-emergency basis, a registered nurse will perform regular reviews of your medical progress. This will be accomplished through consultations with your doctors and nurses and, with your consent, through the review of your medical records. A signed release may be needed in some circumstances to authorize the nurse to review the medical records. This concurrent review is to help assure that you receive appropriate medical services.
- Another benefit of this concurrent reviews is that it allows Utilization Management to identify cases that require extended hospitalization and use of the Discharge Planning Program. Discharge Planning involves the exploration of opportunities that would allow discharge from the hospital only when it is prudent. Utilization Management will coordinate Discharge Planning with your doctors, hospital nurses and social service organizations. This is to help see that a smooth and safe transition from the hospital to the home or other health care facility occurs if, for example, extended care or home health services are required.

## **Precertification penalty**

If you do not obtain precertification before a hospital admission or outpatient surgery, you will pay a penalty on the covered charges. This penalty does not count toward your deductible, hospital copay or out-of-pocket limit.

## **Second surgical opinion benefit**

In some circumstances, Utilization Management may require you to get a second surgical opinion. If you see the physician to whom you are referred by Utilization Management, the program will pay 100% of the cost of the second surgical opinion. Otherwise, the program will reimburse the expenses like any other doctor's office visit.

## ***Maternity and newborn care***

Maternity expenses for an employee or an employee's spouse are eligible for reimbursement like expenses for an illness. All the provisions and limitations of the program also apply to pregnancy, except that in accordance with federal law, hospital charges in connection with a covered admission for childbirth will be provided for a minimum of 48 hours in connection with normal delivery and for 96 hours in connection with a cesarean section.

Utilization Management should be contacted to initiate the certification process after the mother's sixth month of pregnancy. Then, when the admission actually occurs, they should be notified again.

Elective abortions are not covered. Also, the program does not cover pregnancy expenses of a dependent child.

### **Newborn care**

It is your responsibility to enroll your newborn child by contacting your Campus Benefits Representative.

The program automatically covers the routine hospital nursery care of newborn children if the mother is covered by the program, and the newborn is enrolled within 31 days. No separate deductible or hospital copay applies to expenses incurred by the newborn while in the hospital following birth.

## ***Prescription drug benefits***

The program, covers most drugs and medicines prescribed by a physician and dispensed by a licensed pharmacist, including syringes needed for administration of a drug.

Benefits for prescription drugs are payable in the same way as other eligible expenses. Once the annual deductible is met, the program, pays 80% of the cost of covered prescription drugs. If your expenses reach the out-of-pocket limit, the program pays 100% of the cost of your eligible expenses, including prescription drugs.

The following drugs and supplies are not covered:

- Non-legend drugs other than insulin.
- Therapeutic devices/appliances.
- Drugs intended for use in a physician's office or other than at home.
- Investigational or experimental drugs including compounded medications for non-medical substitution.
- Prescriptions entitled under Workers' Compensation and/or other municipal, state or federal programs.
- Prescription drugs used for the treatment of infertility or for ovulation stimulation.
- Drugs used in the treatment of sexual dysfunction or gender identity.
- Smoking cessation products.
- Drugs for any cosmetic purpose.
- Over-the-counter drugs and medicines.

## ***Mental health and chemical dependency benefits***

The following limits apply to benefits for mental health and chemical dependency care.

- Inpatient care is covered for up to 31 days per calendar year. After you pay the annual deductible and hospital copay, the program, pays 80% of eligible expenses, or 100% after the out-of-pocket limit is reached. However, all hospitalizations must be precertified as described in the Utilization Management section or a \$500 penalty applies.
- For outpatient care, the program pays 60% of eligible expenses after the annual deductible, or 100% after the out-of-pocket limit is reached, up to a maximum of 30 visits in a calendar year.

# *Eligible Expenses and Exclusions*

## *Eligible medical expenses*

Regardless of whether you select the UM Choice Plus POS Program or the Catastrophic Program, the following expenses are covered, subject to limits otherwise stated (refer to specific HMO schedules for eligible expenses under those alternatives):

- Hospital room and board, and general nursing services. If a private room is used, the plan will pay an allowance equal to the hospital's standard semiprivate rate. If no semiprivate rooms are available, or if your physician certifies that a private room is medically necessary to the treatment of your illness or injury, the plan will pay the hospital's lowest rate for a private room.
- Other inpatient hospital charges for medical care, services and supplies rendered or used during a period of confinement.
- Medical care, services and supplies for outpatient hospital care or the use of a licensed ambulatory surgical center.
- Services of a licensed birthing center.
- Physician's fees for surgical care and for administration of anesthesia.
- Physician's fees for other medical care and services in the office, home or hospital.
- Diagnostic laboratory and X-ray examinations, including professional fees.
- X-ray, radium and radioactive isotopes therapy.
- Services of a registered nurse (RN) or, if an RN is not available, a licensed practical nurse (LPN) for skilled nursing services (provided he or she is not a close relative such as a spouse, brother, sister or parent or a person living at the same residence as the covered individual). However, the plan does not cover *inpatient* private duty nursing care.
- Charges for routine preventive care such as physical exams, Pap tests, mammograms, immunizations, well-baby care or other routine health screenings are covered expenses, except under the Catastrophic Program the only covered preventive care is immunizations up to age 5.
- Charges for insulin, federal legend drugs and medicines obtained only with a doctor's prescription, except items listed in *Exclusions and Limitations*.
- Charges for colostomy, ileostomy and ureterostomy supplies and equipment for self-administered insulin or other biological prescribed by a doctor.
- Prosthetic appliances and hospital-type equipment as follows:
  - Oxygen and the rental of equipment for its administration.

- Rental or purchase or repair, as deemed appropriate by the Plan, of a hospital bed, wheelchair or other durable medical equipment.
- Braces and crutches.
- Prostheses to replace lost body parts or to aid in their functions when impaired by injury or sickness.
- Necessary transportation for emergency situations by professional ambulance, air ambulance, railroad or regularly scheduled airline, from the place of injury or sickness to and from the nearest hospital qualified to furnish special treatment for injury or sickness.
- Medically necessary transportation for non-emergency situations by professional ambulance to and from a hospital, but no more than 150 miles.
- Convalescent care facility charges, up to a maximum of 90 days per calendar year for:
  - Semiprivate room and board.
  - General nursing care.

*Note: To be eligible, convalescent care must begin immediately after a hospital confinement of at least five consecutive days.*

- Services received under a written hospice care plan established by the attending doctor for a covered individual who is terminally ill, including:
  - Room and board and general nursing care in an approved hospice facility.
  - Bereavement counseling and homemaker services provided by a qualified hospice care agency.
- Charges for cardiac or pulmonary rehabilitation programs provided the following conditions are met:
  - There is documentation of an existing cardiac or pulmonary disorder, such as post coronary artery bypass, heart attack, angina pectoris, emphysema, chronic bronchitis, or other serious cardiac or pulmonary conditions.
  - The program is prescribed by and supervised by a qualified doctor.
  - The program includes appropriate monitoring and emergency equipment administered by professionals trained in its use.
  - Your doctor certifies that you successfully completed the program.

*Note: The POS Program and Catastrophic Program covers these services up to a maximum benefit of \$2,000 per calendar year.*

- Membership fees or dues charged by an organization such as a health club or YMCA will not be considered an eligible expense. However, any additional charge for a cardiac or pulmonary rehabilitation program which satisfies the above requirements will be allowed.
- Charges for prompt repair, replacement or treatment of teeth or surrounding tissue injured in an accident.

- Charges by a Christian Science Practitioner who is listed in the Christian Science Journal, when such services are chosen by the covered individual instead of the services of a doctor. This choice must be made at the time the first claim is filed in each calendar year (doctors' services will not be covered during the year such choice is made).
- Charges by a Christian Science nurse, as defined by the plan.
- Charges in connection with voluntary sterilization.
- Charges for blood, blood plasma and blood fractions and their administration.
- Charges for occupational, physical and speech therapy provided by a licensed practitioner not to exceed sixty treatments in a calendar year for the Choice Plus POS Program provided the Physician determines the therapy will result in a significant improvement.
- Mental health and chemical dependency services, subject to the limitations described in the other sections of this booklet.
- Under POS Program only, charges for non-network chiropractic services when medically necessary subject to a maximum benefit of \$1,000 for expenses incurred in any calendar year.
- Charges in connection with coverage for a medically necessary mastectomy, post-mastectomy coverage will specifically be provided as required for compliance with the Women's Health and Cancer Rights Act of 1998 for surgery on the non-diseased breast in order to achieve the appearance of symmetry.
- Inhalation therapy.
- Radiation therapy.
- Allergy testing and treatment.
- Home health skilled nursing care services (excluding meals, personal comfort items and housekeeping services) if approved in advance by the Plan.
- Durable medical equipment as prescribed by a Participating Physician, obtained from a designated provider, and when approved in advance by the Plan. (Prior authorization is required for any such equipment if the cost is \$1,000 or more.)
- Podiatric care when Medically Necessary and rendered by a Participating Physician, if approved in advance by the Plan.
- Pain management and biofeedback, when Medically Necessary and approved in advance by the Plan.
- Surgical treatment related to temporomandibular joint disease.

## ***Exclusions and limitations***

Regardless of whether you select the POS Program or the Catastrophic Program, the following charges will not be considered covered medical expenses (subject to exceptions otherwise stated). *Also, refer to specific HMO schedules for exclusions and limitations under those alternatives:*

- Any charges above the reasonable and customary limits for the service or supply (charges for POS network services will not exceed the reasonable and customary limits).
- Any charges incurred for an injury or sickness entitled to benefits under Workers' Compensation, Occupational Disease Law or similar law.
- Any charges incurred as a result of any injury or illness due to war, whether declared or undeclared, or by any act of international armed conflict involving armed forces of any international authority.
- Any charges you or your covered dependents are not legally obligated to pay. Any discount or write-off of charges by a provider is not considered an eligible expense.
- Any charges that would not be made if the patient had no coverage for medical care.
- Charges for services not performed or prescribed by a licensed doctor and not required in connection with the necessary treatment of accidental injury or illness (except for covered preventive care).
- Any charges for, or in connection with, treatment for cosmetic or reconstructive purposes except for surgery that is necessary for repair of accidental injury or birth defect which interferes with normal functions of the body or causes pain.
- Any charges for dentistry, except as mentioned under the section titled *Eligible medical expenses*.
- Charges for marital or family counseling.
- Any charges for eye or ear examinations, or the purchase, repair or fitting of eyeglasses or hearing aids or other corrective appliances, except when required due to injury.
- Charges incurred as a result of intentionally self-inflicted injuries, unless the injuries are the result of a medical condition such as depression, or injuries sustained during the individual's commission of a crime.
- Any charges that are not incident and necessary to the therapeutic treatment of accidental bodily injury or sickness except preventive care as provided under the POS.
- Any charges for custodial care (services provided mainly to assist the patient in the activities of daily living).
- Any charge for special training where the training is primarily educational rather than medical in nature.
- Any charges made for personal comfort items, including but not limited to television and telephones, appliances and personal comfort items and services including air conditioners, humidifiers, dehumidifiers, air purifiers, duct cleaning, food blenders, exercise equipment, orthopedic mattresses, whirlpools and similar items or services even if recommended by a Physician.
- Charges incurred in connection with abortion, except where the life of the mother would be endangered by continuing the pregnancy.
- Treatment or services for infertility and any treatment or services related thereto, including but no limited to artificial insemination, invitro fertilization or gamete intrafallopian transfer.

- Surrogate pregnancy or reversal of an elective surgical sterilization procedure.
- Genetic counseling, treatment or services.
- Charges for treatment of sexual dysfunction or gender identity.
- Charges for hospice care services which are not included in the written hospice care plan or hospice care charges incurred prior to the date of acceptance of the hospice care plan.
- Charges in excess of \$1,000 for chiropractic care under the POS Program..
- Charges incurred in connection with the pregnancy of a dependent other than a spouse
- Any care, treatment, therapy, procedure, device, supply, drug, or medicine, or the use thereof, which (a) is considered to be Experimental, Investigative, or Unproven by any appropriate federal government department, agency or authority or professional association, or (b) is not commonly or customarily recognized by the medical profession as appropriate or effective for the condition being treated.
- Any treatment or services not listed in *Eligible medical expenses*.
- Acupuncture, naturopathy, or hypnotherapy
- Routine trimming of nails, calluses, and/or corns, except when medically necessary
- Durable medical equipment the cost of which is \$1,000 or more, unless approved in advance by the Network Provider Service Contractors.
- All transplants, except for bone marrow transplants, cornea transplants, kidney transplants, liver transplants, heart transplants and lung transplants, when: (1) neither experimental nor investigational in nature, (2) determined to be Medically Necessary and medically appropriate by the designated Center of Excellence Physician Evaluator and (3) performed in a Plan Center of Excellence.
- Donor fees and transportation costs in connection with organ transplant surgery, except that donor fees are covered for organ transplants permitted above when donor and recipient are both Plan Participants.
- Care while in the custody or care of a government agency (e.g., correctional agency), or under the authority of a court order.
- Physical examinations or immunizations, or diagnostic testing required or necessitated by third persons, such as for employment, flight clearance, summer camp, insurance, etc.
- Elective harvesting and storage of blood from the Member or a donor.
- Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent, child, step child or self.
- Non-surgical treatment of temporomandibular joint disease.

# *Definitions*

**Ambulatory surgical center** means a facility operated primarily for performing surgical procedures under the supervision of a staff of doctors. This facility must have a licensed anesthesiologist to administer anesthesia and remain present during surgical procedures, must provide nursing services and must maintain written agreements with a hospital or hospitals for the immediate admittance of patients who develop complications. This facility must not provide overnight accommodations and must maintain adequate medical records for each patient.

**Coinsurance** is the portion of medical expenses that you are required to pay.

**Copay** is the up-front charge that you pay for network physician office visits, hospital admissions, hospital emergency room visits, and prescription drugs.

**Christian Science nurse** means a person who is listed in the Christian Science Journal and:

- Has completed nurses' training at a Christian Science Benevolent Association sanatorium.
- Is a graduate of another nurses' training course.
- Has had three consecutive years of Christian Science nursing experience, including two years of training.

**Convalescent care facility** means a legally constituted institution for the skilled nursing care of persons recovering from illness or injury with:

- Constant, 24 hour-a-day supervision by a doctor or registered nurse.
- The services of a doctor available at all times.
- Such nursing personnel as may be necessary to provide continuous 24-hour care of the patients.
- Maintenance of a daily medical record for each patient.
- Facilities for the full-time care of five or more patients.

In no event shall the term convalescent care facility include any institution, or part thereof, that is used principally as a facility for the aged.

**Cosmetic surgery** means surgery done to alter the texture or configuration of the skin, or the configuration or relationship with continuous structures of any feature of the human body for primarily personal or emotional reasons.

**Deductible** means the initial amount of covered medical expenses that you pay each calendar year.

**Durable medical and surgical equipment** means equipment that is:

- Made to withstand prolonged use.
- Made for and mainly used in the treatment of disease or injury.

- Suited for use in the home.
- Not normally of use to persons who do not have a disease or injury.
- Not for use in altering air quality or temperature.
- Not for exercise or training.

**Emergency** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

- placing the persons health in serious jeopardy; or
- serious impairment of bodily functions; or
- serious dysfunction of any bodily organs or part.

**Formulary** is a comprehensive list of preferred prescription medications. The formulary is designed to direct your physician to the most therapeutically beneficial and cost-effective medications.

**Health Factor** means an individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, evidence of insurability and disability.

**Health Maintenance Organizations (HMO)** provides a wide range of services to participants and their dependents on a prepaid basis through network health care providers only.

**Hospital** means a facility that:

- Is licensed as a hospital in the jurisdiction where it is located.
- Provides 24-hour continuous nursing service by registered nurses and continuous supervision by a staff of doctors.
- Has full diagnostic, surgical and therapeutic facilities.
- Is primarily engaged in providing diagnosis and medical treatment for injury and sickness.
- Regularly keeps patients overnight.

A residential treatment facility that meets this definition does not qualify as a hospital.

**Mental health condition** means any condition requiring treatment or confinement for mental, emotional or behavioral disorders, including but not limited to neurosis, psychoneurosis, psychosis or personality disorder.

**Network** is a system of selected health care providers, consisting of doctors, hospitals, and other licensed health care facilities that provide care to individuals who use the network.

**Non-Specialist** is a physician who is a member of the UM Choice Plus POS Program and provides primary medical care in one of the following areas: internal medicine, pediatric medicine, and family or general practice.

**Physician (or doctor)** means a legally qualified Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). Also, within the lawful scope of their various professions and subject to the specific benefit limitations of the plan, “doctor” shall also mean persons licensed by the proper regulatory agency of the state to practice chiropractic, dentistry, optometry, podiatry, psychiatry and psychology.

**Plan year** is the calendar year January 1 to December 31.

**Reasonable and customary charge** is the most common charge for a medical service or item in a geographic area.

**Specialty care physician (specialist)** is a physician who provides care in a medical specialty other than internal medicine, pediatric medicine, family or general practice.

**Urgent care** is care that requires immediate medical attention but is not life threatening.

# *Confidentiality of Information*

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the benefits manager.

This Plan, and the University, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact your Campus Benefits Representative. If you have questions about the privacy of your health information or wish to file a complaint under HIPAA, please contact the Privacy Officer identified in the privacy notice.