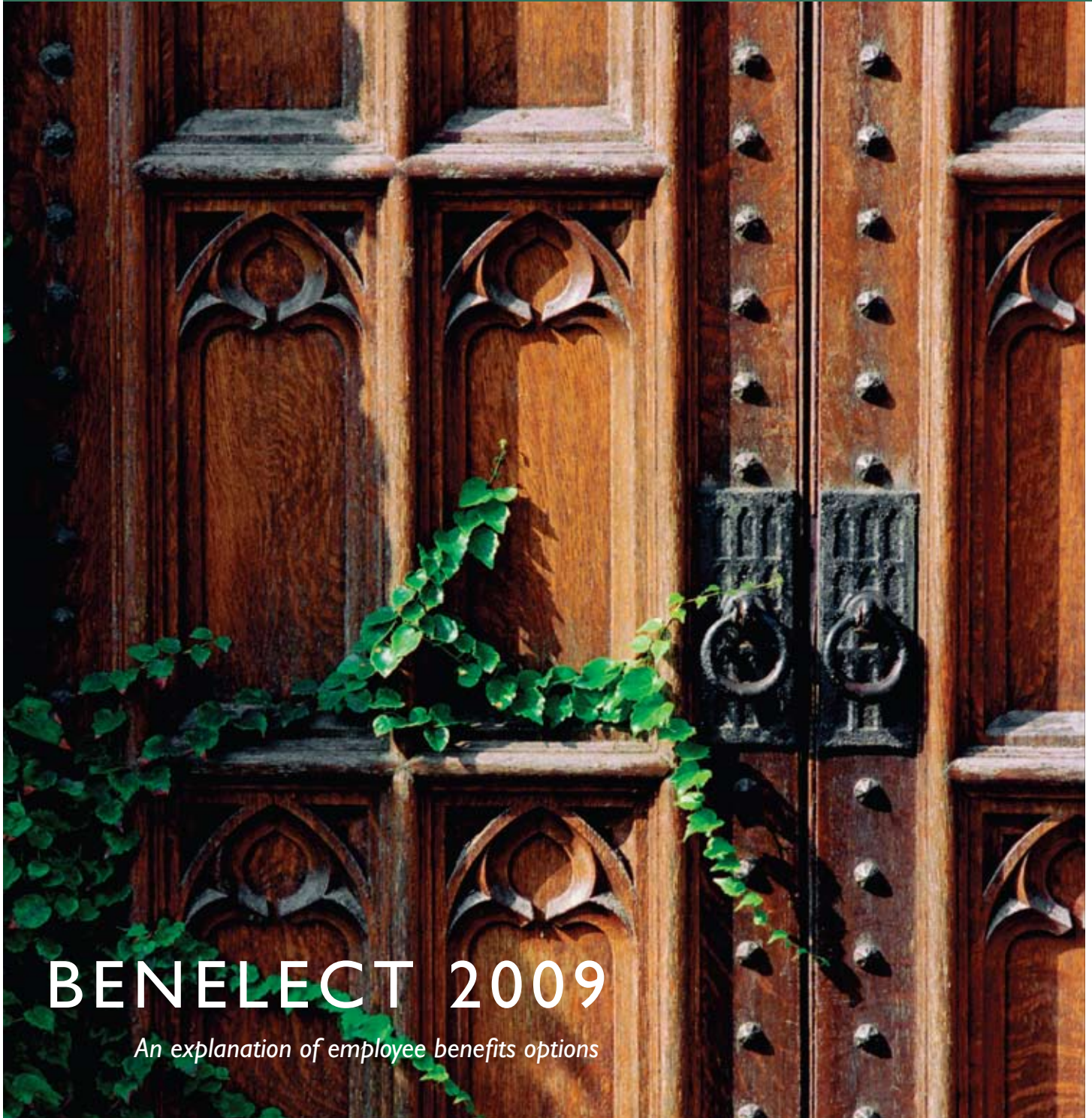




CASE WESTERN RESERVE  
UNIVERSITY EST. 1826



# BENELECT 2009

*An explanation of employee benefits options*

# BENELECT 2009

Case Western Reserve University

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**THIS ENROLLMENT GUIDE** will assist you in electing your benefit choices. The purpose of this guide is to provide you with an overview of Benelect—the flexible benefits program at Case. This is not intended to be a comprehensive description of the benefit plans. Details of individual benefit plans are provided in legal plan documents and contracts that govern the operation of the program. Specific coverage information is contained in the individual summary plan descriptions available from Benefits Administration.

**Benefits on the Web:** The Department of Human Resources has provided links to other plan sites. See the Benefits Page for the resources available to you <http://www.case.edu/finadmin/humres/benefits>

# IMPORTANT INFORMATION

## BENELECT OVERVIEW

Benelect is a flexible benefits program that offers both you and the university a number of advantages. One of the most important advantages is that Benelect offers you choice. You can choose the type of coverage you want, the number of people you want to cover, or you can choose no coverage.

Since faculty and staff choose only the benefits they need, the university can control fringe benefit costs more effectively. And, by providing choices, Benelect does a better job of meeting the diverse needs of staff and faculty.

Benelect also helps you save on taxes. By paying for insurance premiums and putting money into spending accounts on a pre-tax basis, you pay less in Social Security, federal and state income taxes. Using your pre-tax dollars to pay for your benefits and/or spending account deposits will not affect coverage for pay-related benefits such as life insurance, disability coverage, or retirement plan contributions. Those benefits will continue to be calculated from your gross pay.

## EMPLOYER COSTS

The university contributes varying amounts of money towards the purchase of selected benefits. The shared percentages are based on the number of hours worked per week, level of coverage and nonexempt or exempt status.

- Full-time (100 percent): nonexempt employees working 37.5 hours per week or exempt/nonexempt employees working 40 hours per week

- Three-fourths-time (75 percent): non-exempt employees working 28-37.4 hours per week or exempt/nonexempt employees working 30-39.9 hours per week
- One-half-time (50 percent): nonexempt employees working 18.75-27.9 hours per week and exempt/nonexempt employees working 20-29.9 hours per week

## YOUR QUALIFYING FAMILY MEMBERS

For some Benelect benefits, coverage is available not just for you, but for qualifying family members as well. Qualifying family members are:

- Your spouse or equivalent (domestic partner)
- Unmarried children under age 19
- Unmarried, full-time students until they reach age 23
- Unmarried children of any age if they are mentally or physically incapable of supporting themselves

Proof of dependency is required for family members. Proof of domestic partnership through notarized affidavit is required for spousal equivalent coverage. Proof of full-time student status

is required for dependents that have reached age 19. Unmarried children age 19 or older who are not full-time students and full-time students who have reached age 23 are eligible for COBRA coverage if they are currently covered through Benelect. Detailed information can be obtained from Benefits Administration.

## BENEFITS ELIGIBILITY

**Open Enrollment**—Your benefits begin January 1 of the new year and remain in effect for the whole calendar year.

**New Hires**—Your benefits begin when employment is started if the start date is on the first business day of the month; otherwise, benefits begin on the first day of the month following the month in which employment is started.

## MAKING CHANGES DUE TO LIFE EVENTS

The benefit choices you make are in effect for one calendar year and may be changed only during the annual enrollment period to take effect for the following year. The exception to this Internal Revenue Service regulation is a change in family or job status, which allows you to make the appropriate benefit changes mid-year. Qualifying Life Event changes include:

- Marriage or divorce (equivalent or domestic partner)
- Birth or adoption of your child
- Death of your family members
- Change in your child's full-time student status
- Change in your employment status, e.g., from part-time to full-time work
- Gain of insurance through your spouse's (equivalent's) employment
- Loss of your spouse's (equivalent's) medical and/or dental coverage

**These changes in family or job status must be reported to Benefits Administration within 30 days after the life event change occurred along with appropriate documentation.** Only changes that are on account of and correspond with the documented family or job status event can be made. For example, if the documentation you provide is for the birth of a child, the addition may increase the level of coverage (category) to employee plus children or family; however you **cannot** decrease the level of coverage, opt out, add/delete other dependents or change carriers because a decrease would not be consistent with the reason for the change.

Important exception—to family and job status benefit changes is:

- You may change your level of coverage (category) if you meet the criteria, but you may not change health coverage carriers.

## FUTURE RETIREES

When you retire from Case, you can choose one of the medical plans offered (Traditional through Medical Mutual of Ohio (MMO), Preferred Provided Organization (PPO) through Anthem, or Health Maintenance Organization (HMO) through Kaiser Permanente) and/or continue dental coverage that best fits your post-retirement needs. A retiree may change plans at retirement only if the plan they have will not work where they are going to reside. If you have used a local HMO while actively employed at the university and are planning to leave the Cleveland area, for example, you might want to choose the Traditional Indemnity plan or the Anthem PPO plan. Once you've retired, you can change your medical or dental option only during the university's open enrollment period unless there is a qualifying change of status event.

# MEDICAL COVERAGE

Medical benefits provide you and your family with financial protection and access to quality health care. Case medical plans cover expenses for pre-existing conditions. With Benelect, you have several medical plans and coverage levels from which to choose. A medical plan overview is in the back of this guide for the following medical plans:

## MEDICAL MUTUAL OF OHIO (MMO) TRADITIONAL

This comprehensive major medical health care plan does not place any restrictions on which health care provider you use. In this traditional indemnity plan, you must pay the annual deductible before MMO will begin to provide benefits. MMO pays for benefits for covered services through agreements with contracting institutional providers and participating physicians. For non-participating physicians and other professional providers, MMO pays for benefits based on usual, customary, and reasonable (UCR) amounts. Prescription coverage is through a separate pharmacy benefit management (PBM) carrier, CVS Caremark.

## MMO SUPERMED PPO

This PPO allows you full access to medical care from any physician or hospital in the provider network. MMO offers SuperMed Plus, which utilizes an extensive network of hospitals and physicians, but the ultimate choice of providers is yours. SuperMed Plus also includes coverage for medical emergencies in your area, or wherever you travel. Prescription coverage is through a separate PBM carrier, CVS Caremark.

## ANTHEM BLUE CROSS AND BLUE SHIELD BLUE ACCESS PPO

Anthem Blue Access is a PPO which allows you access to the nation's largest network of doctors and hospitals in Ohio, throughout the U.S. and even worldwide. You do not need to designate a primary care physician, nor do you need referrals for services. Prescription coverage is through a separate PBM carrier, CVS Caremark.

## KAISER PERMANENTE HMO

This HMO operates medical facilities in the Greater Cleveland and Akron areas. Kaiser Permanente includes all of the important benefits you expect from a health care plan—quality care and service, comprehensive coverage including prescription benefit, convenience, low co-payments, no deductibles, and no claim forms.

## NO COVERAGE

If you already have medical coverage, another option is “no coverage.”

## COVERAGE LEVEL

Once you choose the medical option that is right for you, you also choose the number of people to cover. You may choose from these coverage categories:

1. Employee
2. Employee + Child(ren)
3. Employee + Spouse (Equivalent)
4. Employee + Family

## COORDINATION OF BENEFITS

If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Benefits section in the plan material and compare them with the rules of any other plan that covers you or your family.

# DENTAL COVERAGE

Under Benelect, you have access to dental coverage through two different carriers, DenteMax or the Case School of Dental Medicine. Dental enrollment is open only in even-numbered years and is a two-year election. Dental enrollment is closed for 2009 open enrollment. New hires may elect coverage upon hire, but the election is locked until the next open enrollment period for dental.

## DENTEMAX

With DenteMax, you may receive care from any dentist, but more of your costs will be covered if you use a dentist who is affiliated with the network. DenteMax is a dental PPO. Participating dentists are searchable online at [www.dentemax.com](http://www.dentemax.com).

Below are some of the basic dental coverage features. Refer to the plan booklet for detailed coverage information.

## COVERAGE LEVEL

As with medical, you have coverage categories from which to choose.

1. Employee
2. Employee + Child(ren)
3. Employee + Spouse (Equivalent)
4. Employee + Family

BASIC DENTAL FEATURES	DENTEMAX PROVIDERS	OUT-OF-NETWORK
Annual Deductible		
<i>Individual</i>	None	\$50 for individual
<i>Family</i>	None	\$100 for family
Annual Maximum Benefit	\$1,500 per person	\$1,500 per person
Preventive Care		
<i>Semi-annual exams and x-rays</i>	100%	70% of usual, customary and reasonable (UCR)
Basic Care		
<i>Fillings, extraction's, oral surgery, periodontia and endontia</i>	80%	60% of UCR
Major Care		
<i>Bridgework, dentures, and crown restorations</i>	60%	40% of UCR
Orthodontic Care		
<i>Children under age 19 only after one year of participation (adult orthodontia is not covered)</i>	50% \$1,250 lifetime benefit	35% of UCR \$800 lifetime benefit

## CASE SCHOOL OF DENTAL MEDICINE

Case School of Dental Medicine is offering two Dental Benefit Plans. The Basic Plan provides a number of diagnostic and preventive services which are covered benefits at a low cost monthly premium for those who do not require major care. The

Comprehensive Plan offers a full variety of services, including those listed below. The care will be primarily provided by graduate dental practitioners at the School of Dental Medicine.

SCHOOL OF DENTAL MEDICINE FEATURES	BASIC PLAN	COMPREHENSIVE PLAN
Deductible	None	None
Maximum Annual Benefit	\$1,500 per year per covered person	\$1,500 per year per covered person
Preventive Care - services such as semi-annual examination and x-rays, cleanings, fluoride and sealants (to age 18)	100%	100%
Basic Care - services such as fillings, non-surgical extraction, oral surgery, periodontia and endodontia	Not Covered	100%
Major Care - services such as bridgework, dentures, and crown restorations	Not Covered	60%
Orthodontic Care - coverage available for children under age 19 only after one year of participation (adult orthodontia is not covered).	Not Covered	50%, \$1,400 lifetime benefit

# VISION COVERAGE

Vision benefits provide you and your family with access to quality vision care. Through Benelect, you have two plans from which to choose. Vision enrollment is open only in even-numbered years and is a two-year election. Vision enrollment is closed for 2009 open enrollment. New hires may elect coverage upon hire, but the election is locked until the next open enrollment period for vision.

## VISION SERVICE PLAN (VSP)

For half a century, VSP has been the leader in eye care wellness benefits. We have a proud tradition of providing quality eye care coverage to employees. VSP is passionate about people and their vision for life, and with over 41 million members nationwide, one in eight people in the United States rely on VSP for eye care health coverage. Vision care is VSP's only business, with a national network of more than 22,000 full-service optometrists and ophthalmologists, at more than 17,600 independent and retail locations, providing over 31,000 points of access nationwide for a member to receive services. In fact, 87% of VSP providers offer extended hours, with 53% having weekend (Saturday and/or Sunday) office hours.

## COVERAGE LEVEL

As with medical, you have coverage categories from which to choose:

1. Employee
2. Employee + Child(ren)
3. Employee + Spouse (Equivalent)
4. Employee + Family

## UNION EYE CARE CENTER, INC.

Union Eye Care offers a voluntary vision plan benefit. The plan provides for an annual eye examination, lenses and frame or contact lenses through any Union Eye Care location. Eye examinations are available through doctors at Union Eye Care, University Ophthalmologists, Inc., University Eye Care and Surgery, Pediatric Ophthalmology, Ophthalmic Consultants of Cleveland and University Ophthalmology Associates locations. The plan also provides for a benefit of 25-45% off eyeglasses and 10-20% off contact lenses through network providers.

## COVERAGE LEVEL

Union Eye Care provides only three levels of coverage:

1. One Person
2. Two Person
3. Family

# PERSONAL LIFE INSURANCE

Life insurance affords your family important financial security. The university provides benefits-eligible faculty and staff with \$20,000 of group term life insurance at no cost to you. Under Benelect, you may purchase additional life insurance, for which the university pays a portion of the coverage.

No matter how much personal life insurance you choose, your coverage also will provide you with an equal amount of accidental death and dismemberment (AD&D) coverage. The AD&D benefit is payable to you in certain types of accidents or to your beneficiary if you die as a result of an accident.

## ADDITIONAL LIFE INSURANCE

If you want more than the basic \$20,000 coverage provided by the university, the cost for additional coverage is based on multiples of your salary and your age as of October 31 of the current year. You may choose an amount from these options:

- A. Basic \$20,000 (no cost to you)
- B. One times salary
- C. One and one-half times salary
- D. Two times salary
- E. Two and one-half times salary
- F. Three times salary
- G. \$50,000

The maximum amount of coverage available under Benelect is \$500,000.

If you choose an amount greater than \$20,000, your basic coverage is part of (not in addition to) the additional amount. For example, if you choose \$50,000 of coverage you pay for only your portion of the \$30,000 of additional coverage. The benefit is reduced by 35% at age 65, and further reduced to 50% of the original amount at age 70; the premium reflects the reduced benefit.

## EVIDENCE OF INSURABILITY

*Open Enrollment*—If you were enrolled in Benelect last year and want to increase your coverage by any amount, you must provide evidence of insurability. Changes in the amounts of insurance will take effect on the first day of the policy month coincident with or next following the date stated in the notice.

*New hires*—Policies are guaranteed issued at up to two times your salary. If your election is greater than two times your salary, you must provide evidence of insurability.

## NAMING A BENEFICIARY

You should have a beneficiary designation on file with Benefits Administration. If not, forms are available in the Benefits office. If you die while covered under Benelect and have not named a beneficiary, or the named beneficiary dies before you, your benefit will be paid in order of survivorship shown in the group insurance plan description.

## ACCELERATED BENEFIT

Personal life insurance includes a provision allowing for an accelerated insurance benefit to be paid if you become terminally ill. This benefit is payable if you are suffering from an incurable, progressive, and medically recognized disease and are not expected to survive more than six months beyond the date of the request for this benefit. You may request up to 75 percent of the life insurance coverage as an accelerated benefit, to a maximum of \$250,000.

## IMPUTED INCOME

Life insurance is a tax-free benefit in amounts up to \$50,000. The Internal Revenue Service requires you to pay income tax on the value of any amount exceeding \$50,000. The IRS-determined value is called “imputed income” and is calculated from the government’s “Uniform Premium Table I.” A copy of this table is available from Benefits Administration.

# LONG-TERM DISABILITY

Long-term disability (LTD) coverage provides you and your family with important financial protection if you are ever disabled. The university pays for this coverage—there is no cost to you!

You receive 60% of your pay, minus any primary Social Security payments, workers compensation and other group LTD benefits you receive while you are disabled for longer than 180 days. The maximum monthly benefit is \$6,000; the minimum monthly benefit is \$100. LTD payments continue until:

- your disability ends,
- you begin working,
- your retirement,

- your death, or
- if you became disabled at age 60 or later, refer to the following schedule.

LTD coverage is in addition to the university's income protection plan, which allows staff members to draw from their balance up to a maximum of 26 weeks within any twelve month time period for personal medical leave, depending on your accrued balance. LTD benefits are taxable when paid to you.

AGE AT DISABILITY	MAXIMUM BENEFIT PERIOD
	To age 65 (but not
Less than age 60 .....	less than 60 months)
60 .....	60 months
61 .....	48 months
62 .....	42 months
63 .....	36 months
64 .....	30 months
65 .....	24 months
66 .....	21 months
67 .....	18 months
68 .....	15 months
69 .....	12 months

# HEALTH CARE SPENDING ACCOUNT

You can make before-tax deposits to your Health Care Flexible Spending Account (from \$10-\$416/month), then reimburse yourself for certain expenses tax free. Your deposit amount cannot be changed, stopped, or started during the year, except for a change in the deposit amount that is on account of and corresponds to a documented change in family or job status. The change in deposit amount must be consistent with the change in family or job status.

Below are examples of medical care services, equipment, and supplies that may be considered eligible health care expenses. Please note that each claim for reimbursement is reviewed individually in accordance with the Benelect plan and applicable law.

Insurance premiums cannot be reimbursed through this account. If you have a question about whether or not an expense is reimbursable, please contact the third party administrator, Meritain Health at 1-877-801-1500. Claims for reimbursement must total at least \$50 and are processed weekly by Meritain Health. You will receive an account statement each time you are reimbursed. For expenses incurred in a given calendar year, you have until June 30 of the following year to submit your claims for reimbursement.

## IRS RULES

Spending accounts are governed by Internal Revenue Service rules. Please refer to IRS guidelines for specifics. In addition, the IRS says that any unspent balance at the end of the year must be forfeited. This “Use or Lose” rule is the trade-off for the tax advantages you enjoy by using the accounts. In addition, if you terminate your participation in a spending account, only expenses incurred prior to the termination date can be considered for reimbursement. Since this account is to be used for predictable expenses, careful planning should help you avoid any forfeiture. Any money forfeited at the end of the year will be used to offset the costs of administering Benelect. The account can reimburse expenses for legal dependents, but does not recognize spouse-equivalent status, therefore, you cannot be reimbursed for a domestic partner’s health care expenses. By law, spending account balances do not earn interest.

## ELIGIBLE HEALTH CARE EXPENSES

Abortion	Contact lenses	Legal fees paid to authorize treatment for mental illness	Special telephone for a deaf person
Acupuncture	Crutches	Lifetime care (advance payment for a physically or mentally handicapped dependent if you should die or become unable to provide care)	Special television for a deaf person
Alcoholism (treatment for)	Deductibles	Medicine	Sterilization
Ambulance	Dental treatment	Nursing homes (for medical reasons only)	Surgery
Artificial limb	Drug addiction (treatment for)	Nursing services	Therapy
Birth control pills	Eyeglasses	Over-the-counter Drugs	Transplants
Braille books and magazines	Guide dog	Oxygen	Vision care
Car with special hand controls or other equipment for use by a handicapped person	Health club for medical reasons prescribed by a doctor	Psychiatric care	Wheelchair
Chiropractors	Hearing care/aids	Psychoanalysis	X-ray fees
Christian Science practitioners	Hospital services	School for a mentally or physically handicapped person	
Co-insurance	Laboratory fees		
	Laetrile		
	Learning disability (treatment for)		

# HEALTH CARE SPENDING ACCOUNT WORKSHEET

This worksheet can help you estimate predictable health care expenses for the upcoming year.

ELIGIBLE MEDICAL EXPENSES	ESTIMATED ANNUAL EXPENSES
Deductibles	\$ _____
Copayments	\$ _____
Amounts above plan limits	\$ _____
Well-baby care	\$ _____
Routine physicals or examinations	\$ _____
Expenses not covered by your medical plan	\$ _____
Expenses not covered by your dental plan (orthodontia)	\$ _____
Vision care (glasses, contact lenses)	\$ _____
Hearing Care	\$ _____
Over-the-counter drugs	\$ _____
Other: _____ _____	\$ _____
Add Total Annual Health Care Expenses	\$ _____
Monthly Total (divide annual expenses by 12)	\$ _____

*Enter this monthly amount when making your benefit elections.*

# DEPENDENT CARE SPENDING ACCOUNT

You can use a Dependent Care Flexible Spending Account to make before-tax deposits (from \$10-\$416/month), to be reimbursed for expenses incurred for care of your children or certain qualifying adults. If you and your spouse file separate tax returns or your spouse uses a separate dependent care spending account, the most you may deposit in your dependent care spending account is \$208 per month (\$2,500 per year).

Expenses for these qualifying family members are eligible for reimbursement:

- Children under age 13 who qualify as dependents on your federal income tax return. (This IRS-regulated account does not recognize spouse equivalent status, therefore, you cannot be reimbursed for dependent care expenses for children of domestic partners.)
- Other qualifying family members who are physically or mentally incapable of caring for themselves (such as a parent whom you support) and who qualify as dependents on your tax return.

The care must be necessary so that you and your spouse (if you are married) can work, actively look for work, or attend school full time. Care can be given in a private home (including yours) or in a day care center. Overnight camp expenses are not reimbursable. Homes and centers caring for more than six people must meet state and local license requirements.

Claims for reimbursement must total at least \$50 and are processed weekly by a third party administrator, Meritain Health. You will receive an account statement each time you are reimbursed. For expenses incurred in a given calendar year, you have until June 30 of the following year to submit your claims for reimbursement.

## LIFE EVENT CHANGES

If your family or job status changes, for reasons specified in IRS regulations, you can start or stop a Dependent Care Spending Account, and under certain circumstances you can change the amount of the deposit. An account can be stopped or started, or the deposit amount can be changed only if the change is consistent with the change in family or job status. For more information, please refer to the summary of permissible life event changes stated on page 1 of this booklet.

## FEDERAL TAX CREDIT

If you have dependent care expenses, you may be eligible for a tax credit on your federal income tax return. You cannot apply the same expenses to both a spending account and the tax credit, however. In general, if your annual family income is \$24,000 or more, you probably will have more savings through the spending account. Your particular situation (and your possible eligibility for an earned income tax credit) will determine which method is better for you. You will need to choose which tax-saving method makes more sense for your family. By law, spending account balances do not earn interest. Money deposited in the health care spending account cannot be used for dependent care expenses, and vice versa.

## DEPENDENT CARE SPENDING ACCOUNT WORKSHEET

This worksheet can help you estimate dependent care expenses for the upcoming year.

### WEEKLY QUALIFIED DEPENDENT CARE EXPENSES

Baby sitter	\$ _____
Day care center	\$ _____
Nursery school	\$ _____
After-school care	\$ _____
Home health care worker	\$ _____
Care for eligible adult	\$ _____
<b>Add Total Weekly Expenses</b>	\$ _____
Number of weeks care is needed	X _____
<b>Total Annual</b> Dependent Care Expenses	\$ _____
Divide by 12 to calculate <b>Monthly Total</b>	\$ _____

*Enter this monthly amount when making your benefit elections.*

## IRS RULES

Spending accounts are governed by Internal Revenue Service rules. Please refer to IRS guidelines for specifics. In addition, the IRS says that any unspent balance at the end of the year must be forfeited. This "Use or Lose" rule is the trade-off for the tax advantages you enjoy by using the accounts. In addition, if you terminate your participation in a spending account, only expenses incurred prior to the termination date can be considered for reimbursement. Since this account is to be used for predictable expenses, careful planning should help you avoid any forfeiture. Any money forfeited at the end of the year will be used to offset the costs of administering Benelect.

For expenses to be reimbursed, care cannot be given by anyone you claim as a dependent on your tax return. You can be reimbursed for expenses paid to a relative age 19 or older if you do not claim the person as a dependent. You must submit a receipt from your caregiver, showing the caregiver's taxpayer ID. Any amount deposited in your dependent care spending account will be reported on your W-2 form at the end of the year.

# OPTIONAL AFTER-TAX ENROLLMENT

Internal Revenue Service rules require you to use after-tax dollars to pay for any of these optional benefits. After-tax benefits are available through payroll deduction. Voluntary benefits begin January 1 and will remain in effect for the whole calendar year (except for group auto and home and long-term care).

## GROUP AUTO AND HOME

MetLife Home & Auto underwrites the MetPay group auto and home program. MetPay offers employees a wide range of quality coverage including automobile, home, boat, umbrella, and other personal property and liability insurance at special rates and discounts. Cost of coverage is based on an individual basis. Inquire by phone 1-800-438-6388 for a policy quote. Coverage begins and ends according to your individual policy.

## PREPAID LEGAL

Hyatt Legal Plans offers representation for many personal legal services through the prepaid Legal Plan. Covered services include wills and estates, debt matters, injury and insurance, traffic, criminal, and real estate. In addition, you may receive telephone advice and office consultations for virtually any personal legal matter. This gives you the opportunity

to discuss with an attorney any personal legal problems that are not specifically excluded matters, even if the matter is not fully covered.

*In Network*—All covered services are paid in full and require no claim forms.

*Out of Network*—You may choose a non-plan attorney and be reimbursed according to a set fee schedule. Contact Hyatt Legal Plans at 1-800-821-6400 prior to meeting with a non-plan attorney to obtain the fee schedule.

## LONG-TERM CARE

MetLife offers a long-term care (LTC) program. LTC is the assistance that is provided to people who are unable to perform simple, everyday activities due to an unexpected accident or serious illness. Inquire by phone 1-866-414-7076 for a policy quote. Coverage begins and ends according to your individual policy.

## DEPENDENT LIFE

Dependent life insurance is a benefit that will be paid to you if your spouse (equivalent) and/or child dies. The insurance carrier quotes the same price tag for covering just a spouse (equivalent) or an entire family because it is more cost effective. You can choose from two levels of coverage:

- \$5,000 spouse / \$1,000 each child
- \$10,000 spouse / \$2,000 each child

No person may be covered both as a Case employee and as a dependent of an employee; and no person may be covered as a dependent of more than one employee. If you and your spouse both work for the university, you may not elect the spousal life insurance and only one of you may elect dependent life insurance for your children. Coverage for spouse ends upon attainment of age 85. Please notify Benefits Administration to stop deductions for Dependent Life. Coverage for dependent child(ren) ends at age 19 or, if a full time student, at age 23.

# BENELECT ENROLLMENT

After you've decided on your pre-tax Benelect options, add all of your premiums to calculate the amount of pre-tax dollars that will come out of your monthly pay. If you are paid semi-monthly, half of this amount will come out of each paycheck.

## USING HCM DURING OPEN ENROLLMENT

Use PeopleSoft Human Capital Management (HCM) to enter your choices on the computer during the enrollment period. Complete any appropriate enrollment applications and return them to Benefits Administration.

If you take no action in HCM during the open enrollment period, your 2009 Benelect elections will automatically default to the same coverage in effect during 2008. Please take a moment to review your current elections before making your 2009 benefit coverage choices.

## NEW HIRE ENROLLMENT

Use the enrollment worksheet to make your decisions by circling the options you want. Then sign and return the form along with any relevant applications to Benefits Administration within the first 30 days of employment. If you do not enroll within the first 30 days of your employment, you will be limited to the basic life insurance coverage of \$20,000. You will have to wait until the next annual open enrollment period to sign up for benefits, which would take effect for the following year.

## MARRIED COUPLES WORKING AT CASE OPTIONS:

- Each spouse can select employee only, or
- One spouse can take employee + child(ren) and the other must select employee only, or
- One spouse can select family coverage and the other waive benefits coverage

# MEDICAL PLAN OVERVIEW

Medical Plan Features	Anthem Blue Access PPO		MMO Traditional
	Network	Out-of-Network	
Primary Care Physician (PCP/SCP)	Any network physician	Not required	Not required
Usual, Customary, and Reasonable (UCR) Fee Limits	Yes	Yes	Yes
Annual Deductible			
Individual	None	\$400	\$400
Family	None	\$800	\$800
Annual Out-of-Pocket Limit (not including deductible)			
Individual	None	\$1,500	\$1,500
Family	None	\$3,000	\$3,000
After meeting annual limit	--	100% paid	100% paid (30/70 MMO facility)
Maximum Benefit	Unlimited	Unlimited	\$2,000,000 per year
Medical Necessity	Required	Required	Required
Medical Claim Forms	None	Required	Required
Physician Office Visits	\$20 co-payment	30/70% co-insurance	20/80% co-insurance
Specialty Care Visits	\$20 co-payment	30/70% co-insurance	20/80% co-insurance
Diagnostics	100% paid	30/70% co-insurance after deductible	20/80% co-insurance
Hospital Services			
Inpatient	100% paid	30/70% co-insurance after deductible	20/80% co-insurance if MMO facility; otherwise 20/80% co-insurance
Emergency Care	\$50 co-payment	20/80% co-insurance after deductible	20/80% co-insurance
Urgent Care	\$35 co-payment	Coverage may not be available if not pre-authorized by Anthem	Call Preview two weeks prior to admission or payment
Pre-certification	Provider handles		
Preventive Care	Covered (see Office Visits); No Dollar Maximum	30/70% co-insurance after deductible	Not covered, except mammogram and Pap smears
Second Surgical Opinion	Voluntary	Voluntary	Voluntary
Mental Health (MH) and Substance Abuse (SA)	No Referrals Necessary	No Referrals Necessary	20/80% co-insurance
Inpatient Hospital	30 days/year each for MH and SA (net and non net combined)	30/70% co-insurance after deductible	30 days per year
Outpatient Care	25 visits/year each for MH and SA \$20 co-payment (net and non net combined)	30/70% co-insurance after deductible	13 visits per year
Pre-certification	Provider Handles	Provider Handles	Call Preview two weeks prior to admission or payment
Prescription Drugs (30 day supply)	Through Caremark: \$15 co-payment generic \$30 co-payment brand formulary \$60 co-payment non-formulary	No benefit from out-of-network pharmacy	Through Caremark: \$15 co-payment generic \$30 co-payment brand formulary \$60 co-payment non-formulary

(Effective January 1 through December 31, 2009) Refer to plan booklets for detailed coverage information

Plan	SuperMed PPO		Kaiser HMO
	Network	Out-of-Network	
	Any network physician	Not required	Required
	Yes	Yes	No
	None None	\$400 \$800	None None
0% co-insurance if non-person	None None -- Unlimited	\$1,500 \$3,000 100% paid 2,000,000 per person	None None -- Unlimited
	Required	Required	Required
	None	Required	None
ance ance ance after deductible	\$20 co-payment \$20 co-payment 100% paid	20/80% co-insurance after deductible (medical necessity)	\$20 co-payment \$20 co-payment 100% paid
ance after deductible otherwise, 44/56% co- ance after \$35 co-pay o days prior to scheduled y \$250 per stay penalty	100% paid \$50 co-payment  Provider handles	20/80% co-insurance after \$100 deductible per confinement & calendar year deductible  Member must call	100% paid  \$50 Co-payment \$35 Co-payment  Provider handles
cept one annual d pap test	Covered (see Office Visits); 100% paid for immunizations	Not covered	Covered immunizations Pneumococcal, Influenza, Hepatitis B, Other Medical necessary immunizations: No Charge
	Voluntary	Voluntary	Voluntary
ance up to:  r  r  o days prior to scheduled y \$250 per stay penalty	MH--30 days per benefit period SA--100% paid up to 15 days per calendar year  MH/SA--100% paid after \$20 co-payment per visit up to 20 visits per year	MH/SA--20/80% co-insurance after \$100 deductible per confinement and calendar year deductible  MH/SA--20/80% co-insurance after deductible, up to 20 visits per year	Detoxification in a general hospital N/C Detoxification in a specialized facility-I admit per year: No Charge 30 days per year  20 visits per year \$20 co-payment, group therapy \$10 co-payment (counts as 1/2 visit)
ark: generic brand formulary non-formulary	Through Caremark: \$15 co-payment generic \$30 co-payment brand formulary \$60 co-payment non-formulary	No benefit from out-of-network pharmacy	Through Kaiser Pharmacy \$15 co-payment generic \$30 co-payment brand up to 62 day supply

# GLOSSARY OF BENEFITS TERMS

## COBRA

(Consolidated Omnibus Budget Reconciliation Act of 1985): Part of this law requires employers to continue offering health coverage for enrollees and their dependents for a period of time after an enrollee leaves the employer. Typically, the employee pays the entire monthly premium when covered by COBRA.

## CONVENTIONAL/INDEMNITY/TRADITIONAL HEALTH PLAN:

Plan participants have no restrictions on which health care providers they use. Plan participants or providers are reimbursed following submission of a claim on a fee-for-service basis. All providers of the same service are reimbursed at the same level.

## CO-PAYMENT:

A fixed sum and/or percentage that an enrollee pays for specific health services, regardless of the total charge for service (the insurer pays the rest of the total charge). For example, an enrollee may pay \$10 co-payment and 20 percent of the total charge for each doctor's office visit, \$75 for each day in the hospital, and \$25 for each prescription.

## CO-INSURANCE:

The portion of covered health care costs for which the covered person has a financial responsibility, usually according to a fixed percentage.

## DEDUCTIBLE:

A predetermined annual amount an enrollee must pay before the insurer will begin paying their portion of covered expenses. For example, if the plan has

a \$400 deductible, the insured person would be responsible for the first \$400 of his or her health care bills.

## DOMESTIC PARTNER:

See definition of Spouse equivalent.

## DRUG FORMULARY:

A listing of prescription medications (name brand and generic) which are preferred for use by the health plan and which will be dispensed through participating pharmacies to covered persons. This list is subjected to periodic review and modification by the pharmacy benefit management plan.

## ELIGIBLE PERSON/EMPLOYEE:

One who meets the requirements specified to qualify for coverage under a health plan.

## ELIGIBILITY DATE:

The defined date a covered person becomes eligible for benefits under an existing contract.

## EVIDENCE OF COVERAGE:

A detailed description of the benefits included in the health plan. An evidence/certificate of coverage is required by state laws and representative of the coverage provided under the contract issued to an employer.

## EXEMPT:

Classification of employees in executive, administrative, professional, and certain computer positions that are exempt from the Fair Labor Standards Act requiring employees to be paid at least the federal minimum wage and overtime pay

of one and one-half times the regular rate of pay for all hours worked over 40 hours in a workweek. If you are an exempt employee at Case (and are paid once a month), you are paid to work 40 hours or more per workweek and are not eligible for overtime pay.

## HEALTH MAINTENANCE ORGANIZATION (HMO):

Plan participants obtain comprehensive health care services from a specified list of in-network providers who receive a fixed periodic prepayment from the insurer. Plan participants' access to in-network providers is controlled by a primary-care physician or gatekeeper. HMOs typically do not have a deductible.

## MANAGED CARE:

A system of healthcare delivery that influences utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to quality healthcare in a cost-effective way.

## MEDICALLY NECESSARY:

The evaluation of health care services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.

## MEDICARE:

A nationwide, federally administered health insurance program which partially covers the costs of hospitalization, Medicare care, and some related services for eligible persons. Medicare

has two parts: Part A—covers inpatient costs. Medicare pays for pharmaceutical services provided in hospitals, but not for those provided in outpatient settings. Medicare is also called supplementary medical insurance. Part B—covers outpatient costs (i.e. physician office visits, lab, and x-ray)

#### MEMBERS:

Participants in health plan (subscribers/enrollees and eligible dependents), who make up the plan's enrollment.

#### NON-EXEMPT:

The Fair Labor Standards Act prescribes standards for wages and overtime, which requires the university to pay its nonexempt employees (who are paid semi-monthly) at least the federal minimum wage and overtime pay of one and one-half times the regular rate of pay for all hours worked over 40 hours in a workweek. Depending upon your position at Case as a nonexempt employee, you are paid to work either 37.5-hours per week or 40-hours per workweek.

#### PRE-EXISTING CONDITION:

Any medical condition that has been diagnosed or treated within a specified period immediately preceding the covered person's effective date of coverage under the group contract.

#### PREFERRED PROVIDER ORGANIZATION (PPO):

Plan participants may seek care from an in-network provider or from an out-of-network provider, but the plan makes no provision to couple a patient with a primary-care physician or gatekeeper.

Typically, the patient pays more for services from an out-of-network provider.

#### PREMIUM:

The amount paid by an enrollee and/or employer to an insurance company or insurance carrier for coverage.

#### PREVENTIVE CARE:

Comprehensive care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination, immunization, and well person care.

#### PRIMARY CARE:

Basic or general health care, traditionally provided by family practice, pediatrics, and internal medicine

#### PRIMARY CARE PHYSICIAN (PCP):

A physician the majority of whose practice is devoted to internal medicine, family/general practice and pediatrics.

#### PROVIDER:

A physician, hospital, group practice, nursing home, pharmacy, or any individual or group of individuals that provides a health care service.

#### REFERRAL:

The recommendation by a physician and/or health plan for a covered person to receive care from a different physician or facility.

#### SECOND OPINION:

An opinion obtained from an additional

health care professional prior to the performance of a medical service or a surgical procedure. May relate to a formalized process, either voluntary or mandatory, which is used to help educate a patient regarding treatment alternatives and/or to determine medical necessity.

#### SERVICE AREA:

The geographic area serviced by a health plan as approved by state regulatory agencies.

#### SPOUSE EQUIVALENT:

The same- or opposite-sex domestic partner of a benefits-eligible employee. Eligibility for medical and dental insurance is contingent upon completion of affidavit

#### SUBSCRIBER:

The person responsible for payment of premiums or whose employment is the basis for eligibility for membership in an HMO or other health plan.

#### USUAL, CUSTOMARY AND REASONABLE AMOUNT (UCR AMOUNT):

The maximum amount allowed (reimbursable) for a covered service provided by a physician and other professional provider based on the provider criteria (see appropriate certificates of coverage).

#### UTILIZATION:

The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time.



CASE WESTERN RESERVE  
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