University of Idaho

Summary of Benefits for

Post-Medicare Eligible Retirees and Family Members

Calendar Year 2014

Legal Disclosure:

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Table of Contents

Summary of Benefits for Post-Medicare Eligible Retirees **3**
Important Information 3

Your Medical and Prescription Drug Coverage **4**
How do I locate in-network providers? 5

Post-Medicare Medical Plan Coverage At-a-Glance Chart **6**

Post-Medicare Prescription Drug Coverage At-a-Glance Chart **10**
Plan A 10
Plan B 10
What the Prescription Drug Plan Covers .....

Participating in the Plan **11**
Eligible Dependents 11
Coverage Levels 11
Making Changes 12
If You Don't Enroll: Default Coverage 12
How You Pay for Coverage 12
ID Cards 12
If You Move 12

Medical Management Program **13**
Care Management 13
Preauthorization 13

Maintenance of Benefits **15**
Example of Secondary Plan Payment 16
Coordination of Benefits with Medicare 16

Employee Assistance Plan (EAP) **16**
Services Provided 16
How the Program Works 16

Your Health Information **18**

Plan Administration and Contact Information **18**

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Summary of Benefits for Post-Medicare Eligible Retirees

The University of Idaho (the University) offers eligible retirees certain benefits after their University employment ends. Medical benefits are included for all eligible retirees, and eligibility for prescription drug, dental and life insurance benefits is determined based on your eligibility for Tier I, II, III, or IV retiree benefits. Dental and life insurance benefits are described in separate summaries.

The Post-Medicare Retiree Medical Plan (the Plan) applies to you and all of your covered dependents if you are eligible for and have accepted both Medicare Parts A and B and meet other Plan eligibility requirements. You typically become eligible for Medicare Parts A and B at age 65; however, you may qualify for Medicare at a younger age if you have an eligible disability as defined by Medicare.

The Plan has the following benefits:

- Medical and Behavioral Health coverage under one of two Plan options, a standard PPO (Plan A) or a High Deductible Health Plan (Plan B);
- Prescription drug coverage may be available at retail or through mail-order, based on eligibility tier and medical plan chosen;
- Employee Assistance Program (EAP) benefits;
- Optional Dental coverage; and
- Life insurance coverage may be included based on your eligibility tier.

Important Information

The information in this summary is intended to summarize the benefits available to eligible retirees and their dependents. Additional information is available from the benefits section of the University Website or by contacting the respective plan administrators or carriers.

This summary is based on the Retiree Health and Welfare Summary Plan Description (SPD) which is available for your review at University offices during business hours. The Retiree Health and Welfare Summary Plan Description governs the benefits described in this summary. If there is any discrepancy between the descriptions in this summary and the Retiree Health and Welfare Summary Plan Description, the SPD's descriptions will always govern. You and your eligible dependents should not rely on any oral description of the benefits or references in this summary because the written terms of the SPD will always govern. To the extent not delegated, the University shall have the authority to interpret the benefit descriptions in this summary and the related SPD.

If you have any questions after reading this summary, please refer to the "Plan Administration and Contact Information" section for information on where to call.

Plan Amendments

The University can replace the group contracts through which benefit claims are paid under the Medical and Prescription Drug Plans. The University also can amend the Plan or any part of the Plan. Plan amendments may include amendments to terminate coverage for some or all employees/retirees. If the Plan or any part of the Plan is terminated, the rights of a participant covered under the Plan or any part of the Plan are limited to the payment of eligible expenses incurred prior to such termination. Any provisions of the group policy that conflict, as of the policy effective date, with the laws of the state where it is issued are automatically amended to conform to the minimum requirement of the law.

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Your Medical and Prescription Drug Coverage

The University offers you two medical plans from which to choose:

Plan A (Standard PPO)

Plan B (High Deductible Health Plan or “HDHP”)

Your benefits within each plan will vary based on each participant’s Medicare eligibility. This table describes how your University medical benefits work:

Feature	Post-Medicare Eligible Participants	
	University of Idaho Plan A	**University of Idaho Plan B**
How eligible medical care services are covered	The University requires you enroll in Medicare Parts A and B when you are initially eligible. At that time, Medicare becomes your primary coverage; the University plan is your secondary coverage. Please review the *Maintenance of Benefits* section for more information. When you incur an eligible medical expense, your benefits will be determined by the Medicare’s maximum allowable charge for services. Then, the University plan may pay up to the difference between the Medicare payment and the amount that the plan would have paid had there been no coordination with Medicare. Keep in mind, the plan will pay benefits once you have satisfied your deductible. Please see the *Medicare Eligible Medical Plan Coverage At-a-Glance Chart* for more detailed coverage information.	

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Feature	Post-Medicare Eligible Participants	
	University of Idaho Plan A	**University of Idaho Plan B**
How eligible prescription drugs are covered	If you are a Tier 1 retiree, you continue your prescription drug coverage through Plan A. The University will enroll you in a ***Group*** Medicare Part D Plan, please review the separate Prescription *Drug Benefits plan summary* for more information. All other retirees need to enroll in Medicare Part D to receive prescription drug benefits. Tier II and III retirees receive a University stipend to help pay for Medicare Part D coverage.	Plan B does not provide any prescription drug benefits to Medicare eligible individuals. Enroll in Medicare Part D to receive prescription drug benefits.
Network providers	Plan A is considered an "Open Access PPO" plan. This means you may see any provider you choose, either in-network or out-of-network, without a reduction of benefit. However, you receive discounted rates, and you pay less out of your pocket, when you visit an in-network provider.	Plan B is considered an "Open Access PPO" plan. This means you may see any provider you choose, either in-network or out-of-network, without a reduction of benefit. However, you receive discounted rates, and you pay less out of your pocket, when you visit an in-network provider.
Opportunity to contribute to a Health Savings Account	No	No

How do I locate in-network providers?

To locate a provider in your area, please visit the Blue Cross of Idaho Web site at **www.bcidaho.com**. Click on "Find a Provider" and you will be taken to the searchable directory. You may also contact the Customer Services Department listed on your ID card to locate providers in or out of your area.

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Post-Medicare Medical Plan Coverage At-a-Glance Chart

This section provides you with detailed information on medical coverage for Medicare-eligible participants.

Please note that while the chart provides a list of covered services, it is important to contact Blue Cross of Idaho before a service is provided to be sure it is covered and to determine if any special requirements need to be met, such as preauthorization. Contact Blue Cross of Idaho by calling the number listed on your ID card. Additionally, please review the *What the Medical Plans Cover* section of the SPD for more detailed information.

Post-Medicare Medical Plan Coverage At-a-Glance Chart		
Benefit	**University of Idaho Plan A**	**University of Idaho Plan B**
Annual deductible (you pay)	$300 per individual	$1,500 per individual
Preventive care/wellness services (plan pays)	You pay nothing for eligible, in-network care; plan pays 100% of the maximum allowance	You pay nothing for eligible, in-network care; plan pays 100% of the maximum allowance
Preventive care/wellness services include: • **Adult examinations** – Annual physical examinations including Pap tests, fecal occult blood test, PSA tests, cholesterol panel, chemistry panel, diabetes screening, urinalysis, complete blood count, bone density, tuberculosis skin or tine test, uric acid, GGT (liver function test), screening EKG, preventive screening mammogram, colonoscopy/sigmoidoscopy, thyroid stimulating hormone, transmittable disease screening (Chlamydia, Gonorrhea, HIV,HPV, Syphilis, Tuberculosis), aortic aneurysm ultrasound, alcohol misuse assessment, genetic counseling for high-risk family history of breast or ovarian cancer, health risk assessment for depression, lipid disorder screening, smoking cessation counseling visit, dietary counseling (up to three visits per year). • **Well-baby care and well-child care** – Routine or scheduled well-baby and well-child examinations, including Rubella and PKU tests, newborn hearing test, and screening examinations for sports physicals. • **Maternity benefits** – Urine culture, Hepatitis B virus screening, iron deficiency screening, Rh (D) incompatibility screening, Diabetes Screening. • **Immunizations and travel vaccines** – Accellular Pertussis, Cholera, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Human Papilloma Virus (HPV), Influenza, H1N1, Japanese Encephalitis, Measles, Meningococcal, Mumps, Plague, Pneumococcal (pneumonia), Poliomyelitis (polio), Rotavirus, Rubella, Tetanus, Typhoid, Typhim VI, Typhus, Varicella (Chicken Pox), Yellow Fever and Zoster. • **Hearing examination** - Limited to one routine exam by a *qualified medical provider* per participant per benefit period. • **Breastfeeding Support** – Breastfeeding support and supply services, Hospital Grate Breast Pumps require a Prior Authorization • **Domestic Violence** – Screening and assessment for interpersonal and domestic violence		
Out-of-pocket maximum (Once the deductible is satisfied, coinsurance is paid until the out-of-pocket maximum is satisfied, then the plan pays for 100% of covered services)		
	$2,600 per individual	$3,100 per individual
Lifetime benefit maximum	Unlimited	
Ambulance transportation services (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible

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Post-Medicare Medical Plan Coverage At-a-Glance Chart		
Benefit	**University of Idaho Plan A**	**University of Idaho Plan B**
Behavioral health benefits		
Inpatient services (you pay)	20% of the maximum allowance after the deductible, and $100 per day copayment up to 3 days per year	30% of the maximum allowance, after the deductible
Outpatient psychotherapy services (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Facility and other professional services (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Blood service (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Colonoscopy/sigmoidoscopy		
Preventive screening (plan pays)	You pay nothing; plan pays 100% of the maximum allowance	You pay nothing; plan pays 100% of the maximum allowance
Diagnostic service (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Contraceptive services (you pay)		
Bariatric Surgery	$1,500 Deductible, then 20% of the maximum allowance after the deductible	$1,500 Deductible, then 30% of the maximum allowance after the deductible
Birth control pills	See the *Prescription Drug Benefits* section for more information	Not covered
Diaphragms & IUD	In Network services are covered at 100%, Out of Network services: 20% of the maximum allowance, after the deductible	In Network services are covered at 100%, Out of Network services:,30% of the maximum allowance, after the deductible
Depo Provera injections		
Dental services, related to accidental injury (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Diabetes self-management education (you pay) *Limited to $500 per benefit period*	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible for in-network services
Diagnostic services (you pay) *Excluding eligible wellness and preventive care services*	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Durable medical equipment (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Emergency services (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible

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Post-Medicare Medical Plan Coverage At-a-Glance Chart		
Benefit	**University of Idaho Plan A**	**University of Idaho Plan B**
Hearing aid appliances and fitting exams *Limited to $800 per participant per lifetime by a qualified medical provider*	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Home health skilled nursing services	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Hospice services	20% of the maximum allowance, after the deductible *(only from a contracted Hospice)*	30% of the maximum allowance, after the deductible
Hospital services (you pay) – Inpatient – Outpatient – Special services	20% of the maximum allowance, after the deductible Inpatient Services: responsible for 20% co-insurance and $100 per day copayment up to 3 days per year	30% of the maximum allowance, after the deductible
Human growth hormone therapy (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Implantables (for purpose of contraception)	In Network Plan pays 100%, Out of Network Plan pays Plan Pays 100% maximum allowance, after the $100 copay	In Network Plan pays 100%, Out of Network 30% of the maximum allowance, after the deductible
Injections (including allergy injections) (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Inpatient physical rehabilitation care (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Mammogram services		
Preventive screening (plan pays**)**	You pay nothing; plan pays 100% of the maximum allowance for in-network services	You pay nothing; plan pays 100% of the maximum allowance for in-network services
Diagnostic service (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Maternity services (you pay) *See* Bright Beginnings Early Prenatal Management Program *section for more information*	Physician services: $250 copayment, the plan pays 100% (not subject to deductible or coinsurance) Hospital services: 20% of the maximum allowance after the deductible, $100 per day copayment up to 3 days per year	30% of the maximum allowance, after the deductible
Medical services (you pay) – Inpatient – Outpatient	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible

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Post-Medicare Medical Plan Coverage At-a-Glance Chart		
Benefit	**University of Idaho Plan A**	**University of Idaho Plan B**
Outpatient cardiac rehabilitation services (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Outpatient pulmonary rehabilitation services (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Outpatient rehabilitation therapy services (you pay) – Chiropractic care services – Occupational therapy – Physical therapy – Respiratory therapy – Speech therapy	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Post-mastectomy/ lumpectomy reconstructive surgery (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Prescription drug services (Tier I participants only)	CVS Caremark manages prescription drug benefits; please see the *Prescription Drug Benefits* section for more information	Not covered
Selected therapy (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Skilled nursing facility (you pay) *Limited to 30 inpatient days per benefit period*	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Smoking cessation services (you pay)		
Counseling	100% of the maximum allowance	
Medications	50% of the maximum allowance	
Temporo-mandibular Joint (TMJ) Syndrome Services (you pay) *Up to lifetime benefit of $2,000 (in- and out-of-network) per participant*	50% of the maximum allowance, after the deductible	50% of the maximum allowance, after the deductible
Transplant services (you pay) *Limited to a lifetime benefit limit of $5,000 for related living expenses*	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible

Please refer to the SPD available on the Benefit Website or in the Human Resources office for further explanation on general benefit information.

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Post-Medicare Prescription Drug Coverage At-a-Glance Chart

Tier	Post-Medicare Eligible	
	University of Idaho Plan A	**University of Idaho Plan B**
I	Participants receive prescription drug benefits with University medical benefits. The University will enroll you in a ***Group*** Medicare Part D Plan.	Participants need to enroll for prescription drug benefits through Medicare Part D.
II	Participants need to enroll for prescription drug benefits through Medicare Part D. Participants receive a stipend from the University to help pay for coverage. See the *How to Enroll for Coverage* section in the SPD for more information.	
III		
IV	Participants need to enroll for prescription drug benefits through Medicare Part D. See the *How to Enroll for Coverage* section in the SPD for more information.	

Plan A – Tier I Retirees

You pay for the full cost of prescription drugs until you meet the per-individual deductible (or two individual deductibles per family).

Post-Medicare Deductible:

- $225 individual
- $450 family

Once you meet the deductible, you will pay 25% coinsurance for your prescription drugs from the retail pharmacy. However, your coinsurance amount will be subject to a minimum and maximum copayment. If you order from the mail order pharmacy, you will pay a flat dollar copayment. This table shows your costs after you've met the deductible. Please see separate SilverScript Plan summary for additional information.

Plan B

Plan B prescription drug coverage is not available to Medicare eligible employees.

Medicare Plan Options for Retirees in Tier I					
	University of Idaho Plan A			University of Idaho Plan B	
	Retail Pharmacy		Mail Order	Retail Pharmacy	Mail Order
Feature	30-day or less supply through SilverScript pharmacies	90 day or less supply through SilverScript pharmacies	90-day supply through SilverScript	30-day or 90-day or less supply through SilverScript pharmacies	90-day supply through SilverScript
Generic	25% $12 minimum / $25 maximum	25% $36 minimum/ $75 maximum	$36	No coverage	
Formulary Brand Name*	25%* $25 minimum / $75 maximum	25%* $75 minimum / $225 maximum	$75		
Non-formulary Brand* Name	25%* $40 minimum / $100 maximum	25%* $120 minimum / $300 maximum	$120		

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Participating in the Plan

Eligible Dependents

If you elect retiree medical benefits for yourself, you may enroll your eligible dependents that were enrolled for coverage under your active benefits on the date you retire. In addition, dental coverage for dependents must mirror the retiree's coverage, regardless of Medicare eligibility or tier. Prescription Drug coverage will depend upon the individuals Medicare eligibility, for example if a dependent is not Medicare eligible their prescription coverage will be supplied by CVS Caremark, whereas the Medicare eligible retiree's coverage will be supplied by SilverScript.

To qualify as an eligible dependent, a person must be one of the following:

Your spouse under a legally valid marriage (a legally valid marriage includes an opposite-gender marriage or common-law union that began in Idaho prior to January 1996, or a common-law relationship that is valid in another state and is recognized by Idaho state law).

- A spouse who is covered by the University of Idaho's active benefit plan may be enrolled in the retiree health plan upon his or her separation from a benefits-eligible position and/or retirement if:
  - He or she was eligible as your dependent at the time of your retirement, and
  - You request to add your spouse to your coverage within 30 days of his or her separation from a benefits-eligible position and/or retirement.

A child under the age of 26. For purposes of the plan, a "child" means your:

- Biological child,
- Legally adopted child or a child placed with you for adoption,
- Stepchild,
- Child for whom you are the legal guardian, and/or
- Child who is required to be covered by a Qualified Medical Child Support Order (QMCSO)

Coverage will terminate for your child on his or her 26th birthday unless he or she is incapable of self-support because of a physical or mental disability that began prior to age 26. You must apply for this continuation within 31 days after the child reaches age 26.

If you die, your surviving spouse or child(ren) are not eligible for coverage if they are eligible for coverage under another employer's health plan — as either the primary subscriber or a dependent. Waiving coverage under another employer's plan also will result in a loss of eligibility for the Retiree Health Program.

If your spouse remarries, he or she may continue retiree health plan participation assuming he or she meets all other eligibility requirements. A new spouse of a former covered dependent spouse, or any other newly acquired dependent, may not be added to the Retiree Health Program. However, a dependent child of the retiree who is born after the death of the retiree may be added within 60 days of birth.

Coverage Levels

For medical and dental coverage, you can enroll in any of the tiers below when initially eligible:

Retiree Only,

Retiree + Spouse,

Retiree + Child,

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Retiree + Children, and

Employee + Spouse + Child(ren).

Making Changes

In general, the benefit elections you make when you initially enroll will remain in effect permanently. You may be permitted to change whom you cover for benefits under certain circumstances, including:

- Your marriage, divorce (including annulment) or legal separation,
- A child's birth, adoption or placement for adoption,
- Receipt of a Qualified Medical Child Support Order (QMCSO) requiring you to provide coverage for a child,
- Death of your spouse or child,
- Your child reaching the maximum age for coverage (age 26).

If you have an eligible change and want to make a change to whom you cover, you must make the allowed change(s) within 30 days of the event. If you have had a baby, adopted a child or had a child placed for adoption with you, you must make your election changes within 60 days of the birth, adoption or placement for adoption. You may only change whom you provide coverage for – you may not change your plan elections.

You Must Enroll in Coverage

When you retire, you must complete the Benefit Election Form and return it to the University of Idaho. You will not have an opportunity to change your election. *Please note: there is not an annual enrollment period for retirees.*

How You Pay for Coverage

You will receive monthly billing statements from the University of Idaho Benefits Center detailing your payment options.

ID Cards

You and your covered dependents will receive identification cards for medical, prescription drug and dental when your coverage begins. You may request additional cards; each person enrolled on the SilverScript prescription plan will have their own Prescription card and I.D. number.

Remember to carry your ID cards with you at all times. If a provider wants to verify your or your dependent's coverage, have him or her call the number listed on the ID card. In addition, you should use your ID card to contact Blue Cross of Idaho and determine if you need preauthorization.

If You Move

Contact the University of Idaho Benefits Center to update your information:
P.O. Box 25429
Pittsburgh, PA 15220

Phone: 1-800-646-6174 or 208-885-3697
Email: uidahobenefits@hroffice.com

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Medical Management Program

Blue Cross of Idaho's medical management program helps ensure that you receive the right care in the right place at the right time.

Medical management helps you better manage your health, your healthcare and your costs. There are many benefits of medical management, including less work or school missed due to illness, enjoying a better quality of life, staying healthy and living longer. Additionally, you may save money by paying less out of your pocket for healthcare expenses.

The medical management program consists of a number of programs and provisions discussed in this section, including:

- Care management,
- Preauthorization (Medical only)
- Non-emergency preadmission notifications,
- Emergency notifications,
- Continued stay review,
- Discharge planning,
- Disease management, and
- Bright Beginnings Early Prenatal Management Program.

Care Management

The care management program helps you coordinate care before, during and after treatment to ensure continuity of care for participants. It is a collaborative process among Blue Cross of Idaho, participants and providers. The program will help ensure you and your providers know what the plan will cover.

Preauthorization

The preauthorization program is designed to ensure you get the most appropriate, cost-effective care for your condition(s). Under the program, Blue Cross of Idaho determines whether certain services and supplies are medically necessary or otherwise meet the requirements for plan coverage. Services that are authorized by Blue Cross of Idaho will be covered subject to all the other terms and conditions of the plan. Services that are not authorized by Blue Cross of Idaho will not be covered, and you will be financially responsible if you choose to receive those services.

Generally, the provider will obtain the preauthorization, particularly if you use an in-network provider. However, if you use an out-of-network provider, it is your responsibility to make sure that the preauthorization is obtained. If your in-network provider fails to obtain the appropriate preauthorization, you will not be held responsible for the charges if the services are not authorized.

In-network providers should work with Blue Cross of Idaho to complete any preauthorization requirements. However, it is always a good idea to check and ensure preauthorization has been completed.

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When You Have Other Coverage (Maintenance of Benefits)

If you or your eligible dependents are covered by more than one medical plan, reimbursements are coordinated between plans so benefits are not duplicated.

How the Plans Coordinate Coverage

Your medical benefits plan has maintenance of benefits (MOB) provision. This provision coordinates benefit payments from all medical plans that cover you and your eligible dependents, so that plan benefits are maintained at the level set by this plan after payments from all sources of coverage have been considered.

When you have a claim for expenses covered by two or more plans, one plan pays benefits first. This is known as the primary plan. The other plan(s), called the secondary plan(s), then determines how much of the covered services, if any, are to be paid from the secondary plan(s). The Order of Benefit Determination rules in the SPD govern which plan will be considered primary and pay first, and which plan(s) will be considered secondary.

A “plan” is any of the following that provides benefits or services for medical or dental care or treatment:

- Group and non-group insurance contracts,
- Health maintenance organization (HMO) contracts,
- Closed panel or other forms of group or group-type coverage (either insured or uninsured),
- Medical care components of long-term care contracts, such as skilled nursing care,
- Medical benefits under group or individual automobile contracts, and
- Medicare or any other federal governmental plan, as permitted by law.

If separate plans are used to provide coordinated coverage for a group member, the separate plans are considered parts of the same plan, and there is no MOB among those separate plans.

A plan does not include:

- Hospital indemnity coverage or other fixed indemnity coverage,
- Accident-only coverage,
- Specified disease or specified accident coverage,
- Limited benefit health coverage, as defined by state law,
- School accident-type coverage,
- Benefits for non-medical components of long-term care policies,
- Medicare supplement policies, or
- Medicare or any other federal governmental plan, unless permitted by law.

When this medical benefits plan is primary, it pays or provides its benefits according to this plan’s terms of coverage and without regard to the benefits of any other plan.

When this medical benefits plan is secondary, it pays the amount necessary to ensure that the total combined amount you receive from this medical benefits plan and the primary plan is no greater than the amount you would have received under this medical benefits plan alone.

Every effort has been made to make certain that the information in this communication is accurate. However, this communication is only intended to give you an overview of your benefit plans and does not contain all the details about the benefits provided, exclusions and other terms and conditions of the plans. Your benefits are determined according to the official SPD. If the information in this communication differs from the SPD, the SPD will govern in all cases. The University may amend or terminate these plans or any benefits provided by these plans at any time.

Example of Secondary Plan Payment

Under the Order of Benefit Determination Rules, if your enrolled spouse also has medical coverage through his or her employer, your spouse's employer's plan will be the primary payer. The University's benefit plan will be the secondary payer. This means the University's benefit plan will pay up to the amount allowed under this plan's coverage *less* the amount the primary plan already has paid.

For example, let's say that the University's benefit plan provides 80 percent coverage, your spouse's plan covers 50 percent, and your spouse has a covered, payable expense of $100. Your spouse's primary plan will pay 50 percent of the charge ($50), and the University's benefit plan will then pay 80 percent of the charge *less* $50 (in this case, $30) toward the remaining eligible expense.

But if your spouse's plan pays 80 percent and the University's benefit plan also allows 80 percent, no payment will be made by the University's benefit plan; this is because the maximum benefit of 80 percent has already been paid for the service.

Coordination of Benefits with Medicare

When you or your dependent reaches age 65 or becomes disabled, you or your dependent (as applicable) may be eligible for Medicare benefits. Medicare generally provides coverage for people age 65 or older, as well as for people entitled to Social Security disability benefits and those with end-stage renal disease. Once you become eligible for Medicare, Medicare will become your primary medical coverage and your University retiree medical coverage will become your secondary coverage (note that there is a limited exception in the case of end-stage renal disease).

Once you become eligible for Medicare, you should enroll in Medicare Parts A and B to remain eligible for the University of Idaho Retiree Health Plan. That is because the Retiree Medical Plan integrates with Medicare on a maintenance of benefits basis as if you were enrolled in both Parts – even if you are not. If you do not enroll in Medicare Parts A and B, you may not receive the benefits you are entitled to and, therefore, may end up paying more for your medical care. In addition, you may be subject to late enrollment penalties if you don't enroll in Medicare when first eligible.

You should apply for Medicare two to three months before reaching age 65. Contact your local Social Security office before you reach age 65 for more information about Medicare and your eligibility.

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Employee Assistance Plan (EAP)

The Employee Assistance Program (EAP) is a free, confidential service that provides eligible retirees and their families with the opportunity to discuss personal problems with a professional counselor, receive unlimited telephone and Internet access to resource and referral information, and obtain other self-help information.

You do not have to enroll in a medical plan to participate in the EAP. However, if you are enrolled in a medical plan, you may be able to maximize your benefits by accessing the free services of the EAP before using behavioral health benefits, which require you to pay a share of the cost.

Services Provided

The EAP's Master's-level, licensed professional counselors are available to you and your family 24 hours a day, 365 days a year. Counselors can help with any situation that creates stress including:

- Family problems,
- Stress/anxiety,
- Personal relationships,
- Depression,
- Grief,
- Anger management,
- Substance abuse,
- Legal concerns,
- Finances,
- Workplace,
- Aging, and
- Abuse.

How the Program Works

You can call the EAP at **1-800-999-1077**, 24 hours a day, 365 days a year. For online services go to **www.apshelplink.com** (University code: UI1), and for networked providers and company information go to **www.apshealthcare.com**.

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Your Health Information

This section summarizes how medical information about you may be used and disclosed. It also describes how you can access this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This section is intended to satisfy HIPAA's requirement to provide you with notice that the University complies with the HIPAA privacy rules with respect to safeguarding your health information that is created, received or maintained by the University's healthcare plans.

The University's healthcare plans need to create, receive and maintain records that contain health information about you to administer the plans and provide you with healthcare benefits. Under the HIPAA privacy rules, the University's healthcare plans may use and disclose health information about you.

The University's Pledge Regarding Health Information Privacy

The privacy policy and practices of the University's healthcare plans protect the confidential health information that identifies you or could be used to identify you and relate to a physical or mental health condition or the payment of your healthcare expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Additional information about HIPAA privacy rules are provided to you in a Privacy Notice that you receive periodically.

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Plan Administration and Contact Information

Plan Administrator:	University of Idaho 875 Perimeter Drive MS 4322 Moscow, ID 83844-4322 (208) 885-3697 www.uidaho.edu/benefits
Plan Year:	The plan records are administered on a contract year basis beginning January 1 and ending December 31 of each year.
Agent for Service of Legal Process:	University of Idaho 875 Perimeter Drive MS 4322 Moscow, ID 83844-4322
Employer Identification Number:	82-6000945

While the University expects to continue the program indefinitely, it reserves the right to amend, modify, suspend or terminate the program or any of the plans at any time in its sole discretion for active or former employees, as well as for COBRA participants. The University also reserves the right to change the amount of required retiree contributions for coverages under the benefit programs described in this document.

An amendment or termination of the program may affect not only the coverage of active employees (and their covered dependents) but also of COBRA participants and former employees, who retired, died or otherwise terminated employment. A plan change may transfer plan assets and debt to another plan or split the plan into two or more parts. If the University does change or end a plan, it may decide to set up a different plan.

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