## University of Idaho

Summary of Benefits for

# Pre-Medicare Eligible Retirees and Family Members

Calendar Year 2014

#### **Legal Disclosure:**

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## **Summary of Benefits for Pre-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 Pre-Medicare Retiree Medical Plan (the Plan) applies to you and all of your covered dependents if you are not eligible for Medicare and you 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 "HDHP" (Plan B) with a Health Savings Account
  (HSA) option;
- Prescription drug coverage available at retail or through mail-order;
- Employee Assistance Program (EAP) benefits;
- Dental coverage; and
- Life insurance coverage may be included based on your eligibility tier. If eligible, you will
  receive a separate retiree life insurance summary plan description.

## 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, Prescription Drug, Dental and Life Insurance 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.

## **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	Pre-Medicare Elig	gible Participants			
	University of Idaho Plan A	University of Idaho Plan B			
How eligible medical care services are covered	Receive primary medical and prescription drug benefits through the University plan.  Please see the <i>Pre-Medicare Medical Plan Coverage At-a-Glance Chart</i> for more detailed coverage information.				
	Plan A is a traditional PPO Plan.  In this plan, eligible, in-network preventive care is covered at 100%. For all other eligible health care services, you pay 100% of your covered health care expenses until you reach the annual deductible. Once you reach your deductible, you pay coinsurance for covered services until you reach the out-of-pocket maximum. After you reach the out-of-pocket maximum, the plan pays 100% of your covered services for the remainder of the plan year.	Plan B is a qualified high deductible health plan (HDHP). You may be able to contribute to a Health Savings Account (HSA).  In this plan, eligible, in-network preventive care is covered at 100%. In the HDHP, you pay 100% of your covered healthcare expenses until you reach the annual deductible. Once you reach your deductible, you pay coinsurance for covered services until you reach the out-of-pocket maximum. After you reach the out-of-pocket maximum, the plan pays 100% of your covered services for the remainder of the plan year.			

Feature	Pre-Medicare Eligible Participants			
	University of Idaho Plan A	University of Idaho Plan B		
How eligible prescription drugs are covered	You pay 100% of the cost of prescription drugs until you satisfy the separate prescription drug deductible. Once you meet the deductible, you and the University share the costs of your prescription drugs through copayments and coinsurance. Please see <i>Prescription Drug Benefits</i> for more information.	You pay 100% of prescription drug costs until your eligible, combined medical and prescription drug expenses satisfy the deductible. Once you satisfy the deductible, you pay 30% of your prescription drug costs until you reach the out-of-pocket maximum, then the plan pays 100% of covered services and prescription drugs.  Please see <i>Prescription Drug Benefits</i> for more information.		
Network providers	Through this PPO plan, you may choose care from any provider you wish. You will receive greater benefits when you seek care from an in-network provider. When you visit an out-of-network provider, you will first need to meet the out-of-network deductible. You will also pay a higher out-of-network coinsurance rate and have a separate out-of-network, out-of-pocket maximum.	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	Yes, please see the <i>Health Savings Account</i> section for more information.		

## 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.

## Pre-Medicare Medical Plan Coverage At-a-Glance Chart

This section provides you with detailed information on medical coverage for participants not yet eligible for Medicare.

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 for more detailed information.

Pre-Medicare Medical Plan Coverage At-a-Glance Chart						
	University of Idaho Plan A In-Network Out-of-Network*		University of Idaho Plan B (HDHP with HSA Option)			
Benefit			In- and Out-of-Network*			
Annual deductible (you	\$400 per individual	\$600 per individual	\$1,500 per individual			
pay)	\$1,200 per family		\$3,000 per family			
Preventive care/ wellness services (plan pays)	You pay nothing; plan pays 100%	Not Covered	You pay nothing; plan pays 100% of the maximum allowance for in-network services			

#### 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, Syphilis, Tuberculosis), aortic aneurysm ultrasound, alcohol misuse assessment, genetic counseling for highrisk 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.
- Domestic Violence Screening and assessment for interpersonal and domestic violence
- **Breastfeeding Support** Breastfeeding support and supply services, Hospital Grate Breast Pumps require a Prior Authorization

#### **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. Please see "Out-of-Pocket Maximum" in the *General Benefit Information* section for more information.)

Individual	\$2,600	\$5,200 per individual	\$3,100
Family	\$7,800		\$6,200
Lifetime benefit maximum		Unlimi	ted

Pre-Medicare Medical Plan Coverage At-a-Glance Chart					
	University of Idaho Plan A		University Plar (HDHP with I	n B	
Benefit	In-Network	Out-of-Network*	In-Network	Out-of-Network*	
Ambulance transportation services (you pay)	20% of the maximum allowance after the deductible	35% of the maximum allowance after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	
Behavioral health benefits	3				
Inpatient services (you pay)	20% of the maximum allowance after the deductible, and \$100 per day copayment up to 3 days per calendar year	35% of the maximum allowance after the deductible, and \$100 per day copayment up to 3 days per calendar year	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	
Outpatient psychotherapy services (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% 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	35% of the maximum allowance, after the deductible	30% 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	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	
Colonoscopy/sigmoidosc	ору				
Preventive screening (plan pays)	You pay nothing; plan pays 100%	Not covered	You pay nothing; plan pays 100% of the maximum allowance	Not covered	
<b>Diagnostic service</b> (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	
Bariatric Surgery	\$1,500 Deductible, maximum allowance		\$1,500 Deductible maximum allowance		
Contraceptive services (y	ou pay)				
Birth control pills	See Pres	scription Drug Benefits	section for more inforr	nation	
Diaphragms & IUD  Depo Provera injections	20% of the maximum allowance, after the deductible			30% of the maximum allowance, after the deductible	
Dental services, related to accidental injury (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	

	Pre-Medicare Medica University	of Idaho	University Pla	n B	
Develo	Plan		(HDHP with HSA Option)  In-Network Out-of-Network*		
Diabetes self-management education (you pay)	In-Network  20% of the maximum allowance, after the deductible	Out-of-Network*  Not covered	30% of the maximum allowance, after the deductible	Not covered	
Limited to \$500 per benefit period					
Diagnostic services (you pay)  excluding eligible wellness and preventive care services	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% 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	35% of the maximum allowance, after the deductible	30% 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 (Contracting and noncontracting facility providers and facility-based professional providers only)	wance, after the uctible (Contracting allowance, after the allowance, after the deductible sility providers and y-based professional		30% of the maximum allowance, after the deductible	
Hearing aid appliances and fitting exams (you pay) Limited to \$800 per participant per lifetime by a qualified medical provider	allowance, after the deductible all		30% 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 allowance, after the deductible		30% 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	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	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: \$100 per day copayment up to 3 days per calendar year	35% of the maximum allowance, after the deductible  Inpatient Services: \$100 per day copayment up to 3 days per calendar year	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	
Human growth hormone therapy (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	

Pre-Medicare Medical Plan Coverage At-a-Glance Chart					
	University of Idaho Plan A  In-Network  Plan pays 100% of the maximum allowance, after deductible and \$100 copayment  University of Idaho Out-of-Network*  35% of the maximum allowance, after the deductible		University of Idaho Plan B (HDHP with HSA Option)		
Benefit			In-Network	Out-of-Network*	
Implantables (for purpose of contraception) Limited to once every five years			30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	
Injections (including allergy injections) (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% 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	35% of the maximum allowance, after the deductible	30% 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%	Not covered	You pay nothing; plan pays 100% of the maximum	Not covered	
Diagnostic service (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	maximum maximum allowance, after the		
Maternity services (you pay)  See Bright Beginnings Early Prenatal Management Program section for more information	Physician service: \$250 copayment, then plan pays 100% (not subject to deductible or coinsurance)  Hospital services: 20% of the maximum allowance after the deductible, and \$100 per day copayment up to 3 days per calendar year	35% of the maximum allowance after the deductible, and \$100 per day copayment up to 3 days per calendar year	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	
Medical services (you pay) – Inpatient – Outpatient	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	
Outpatient cardiac rehabilitation services (you pay)	20% of the maximum allowance after the deductible	35% of the maximum allowance, after the deductible	30% 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	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	

	Pre-Medicare Medical Plan Coverage At-a-Glance Chart					
	University of Idaho Plan A		University of Idaho Plan B (HDHP with HSA Option)			
Benefit	In-Network	Out-of-Network*	In-Network	Out-of-Network*		
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 allowance, after deductible		30% 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	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible		
Prescription drug services	CVS/Caremark manage Benefits section for more		enefits; please see the	Prescription Drug		
Selected therapy (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible		
Skilled nursing facility (you pay)  Limited to 30 combined inpatient days per benefit period	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible		
Smoking cessation service	ces (you pay)		•	-		
Counseling		100% of the maxi	mum allowance			
Medications		50% of the maxir	num allowance			
Temporo-mandibular Joint (TMJ) Syndrome Services (you pay)  Up to lifetime benefit of	50% of the maximum allowance, after the deductible		30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible		
\$2,000 (in- and out-of- network) per participant  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	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible		

<sup>\*</sup> If your provider's charge is above the maximum allowance, you may be responsible for these additional charges.

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

## **Pre-Medicare Prescription Drug Coverage At-a-Glance Chart**

#### Plan A

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

Pre-Medicare Deductible:

- \$125 individual
- \$250 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.

#### Plan B

In Pre-Medicare Plan B, you pay 100% of prescription drug costs until your eligible, combined medical and prescription drug expenses satisfy the deductible. Once you satisfy the deductible, you pay 30% of your prescription drug's cost until you reach the out-of-pocket maximum, then the plan pays 100% of covered services.

#### **Prescription Drug Benefits At-a-Glance Chart**

	University of Idaho Plan A			University of Idaho Plan B	
	Retail P	harmacy	Mail Order	Retail Pharmacy	Mail Order
Feature	30-day or less supply through CVS/Caremark pharmacies	90 day or less supply through CVS/Caremark pharmacies	90-day supply through CVS/Caremark	30-day or 90-day or less supply through CVS/Caremark pharmacies	90-day supply through CVS/Caremark
Generic	25% \$12 minimum / \$25 maximum	25% \$36 minimum/ \$75 maximum	\$36	30% after deductible	30% after deductible
Formulary Brand Name*	25%* \$25 minimum / \$75 maximum	25%* \$75 minimum / \$225 maximum	\$75	30% after deductible	30% after deductible
Non-formulary Brand* Name	25%* \$40 minimum / \$100 maximum	25%* \$120 minimum / \$300 maximum	\$120	30% after deductible	30% after deductible

## 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 following coverage tiers when initially eligible:

Retiree Only,

Retiree + Spouse,

Retiree + Child,

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.

#### If You Don't Enroll: Default Coverage

If you do not enroll within 30 days of retirement, you will automatically be enrolled in the default coverage. Default coverage is Retiree Plan A. You will not have an opportunity to change your election. *Please note: there is not an annual enrollment period for retirees.* 

## When You Are Eligible for Medicare

Generally, you will become eligible for Medicare on the first day of the month in which you reach age 65. You may become eligible for Medicare at an earlier age if you are disabled or have 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). The amount you pay for coverage may change at that time.

Additionally, if you are enrolled in Plan B or are a Tier, II, III or IV retiree enrolled in Plan A, your prescription drug benefits from the University end once you are eligible for Medicare. At that time, the University will send you a notice of creditable coverage, so you may enroll in Medicare Part D.

Your covered dependent's medical coverage also may change when he or she reaches age 65, or becomes entitled to Social Security disability benefits or has end-stage renal disease, and becomes eligible for Medicare.

#### **Enrolling for Medicare**

To start the process of enrolling in Medicare, either visit your local Social Security office or call 1-800-772-1213. Contact Social Security during the three-month period before you turn age 65. You can also find information about Medicare online at: <a href="http://www.medicare.gov">http://www.medicare.gov</a>.

For more instructions on enrolling for Medicare, please see the SPD.

#### **How You Pay for Coverage**

You will receive a quarterly billing statement from the University of Idaho 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; however, all cards will list the retiree's name only.

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 Human Resource Services to update your information:

208-885-3697 benefits@uidaho.edu

## **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,
- 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.

## **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**.

## **Health Savings Account**

A Health Savings Account (HSA) is a self-funded account permitted under federal tax law that allows you to save money for medical or pharmacy expenses on a tax-favored basis.

An HSA is an individual account that belongs to you and is not part of the University's medical plan. It is portable, which means it is not tied to your University employment. HSAs may earn interest or investment returns, based on the terms. Because the HSA has a special tax-favored status under law, it is governed by numerous mandatory tax rules and regulations.

## Who Is Eligible to Contribute to an HSA

To contribute to an HSA, you must meet certain criteria:

- Be enrolled in a qualified "high deductible health plan," such as Plan B
- Not be covered by another health plan (unless it qualifies as a high deductible health plan) or enrolled in Medicare Part A or B; and
- Not be claimed as a dependent on another person's tax return.

## Contributing to an HSA

You may contribute directly to a Health Savings Account in amounts up to regular IRS limits. You may change your contributions at any time by contacting your HSA provider.

2014 HSA Contribution Amount
You may save up to
\$3,250
\$5,450

## Spending Your HSA Dollars

You may use your HSA funds tax-free to pay for qualified healthcare expenses for you, your spouse and any dependents you claim on your federal tax return\*. Because you own your HSA, you are responsible for ensuring your tax-free withdrawals are spent on qualified healthcare expenses.

Additionally, you can use your HSA funds tax-free to pay qualified healthcare expenses only if you incurred the expenses *after* you established the HSA and only if the expenses are not reimbursed from another source (such as your spouse's health plan).

\* For this purpose, the individual must meet the IRS definition of a "qualifying child" or "qualifying relative." Generally, a qualifying child is a child who is under age 19 (24 if a full-time student) who lives with you for more than half the year and provides less than half of his/her own support), A "qualifying relative" is a family member (or someone who lives with you in your household) who can't be claimed as another individual's qualifying child and who receives more than ½ of his or her support from you. You should consult with your tax adviser for more information.

### **Qualified Healthcare Expenses**

- Any medical expenses used to meet your deductible;
- Any portion of the cost of covered services (your coinsurance) you pay after meeting the deductible;
- Any expenses the IRS considers qualified healthcare expenses for tax purposes. This
  includes expenses such as dental treatment, vision care, hearing aids and over-the-counter
  supplies used to treat illness or injury (such as bandages, crutches and blood-sugar test kits);
- Over-the-counter medications, other than insulin, are qualified health care expenses only
  when prescribed by a physician. Procedures not covered by traditional medical plans, such
  as laser eye surgery and alternative medicine treatments;
- The premiums for coverage (such as COBRA coverage) while you are unemployed;
- Long-term care insurance premiums; and
- Once you reach age 65, Medicare premiums

To learn more about eligible expenses, log on to <a href="https://www.1hsa.com/qualifiedmedicalexpenses.html">https://www.1hsa.com/qualifiedmedicalexpenses.html</a>

## Filing Your Taxes

In return for an HSAs tax-free privileges, the IRS requires documentation. Because you own your HSA, the IRS holds you accountable for monitoring the eligibility of your expenses and maintaining good records. As a result, it is recommended that you retain all covered healthcare receipts for three years.

To help you in filing your taxes, your HSA provider will send you the following IRS forms:

- In January, Form 1099-SA detailing your HSA withdrawals; and
- In May, Form 5498-SA detailing HSA contributions.

Additionally, if you were an active employee at anytime during the previous year, the University's contributions and your payroll contributions will be shown in box 12 of Form W-2, Wage and Tax Statement, with code "W." Use Form 1099-SA to complete IRS tax Form 8889 and file it with your federal tax return.

You should learn the many tax rules that govern the use of HSAs and monitor your contributions and qualified expenses. For more information about HSAs and the tax rules that apply to them, review the material in Publication 969 at **www.irs.gov**.

## When HSA Participation Ends

If you stop participating in a qualified high deductible health plan, you may no longer contribute to your HSA. However, you may continue to access your HSA funds to pay for qualified healthcare expenses for you and your eligible dependents. You may be responsible for account fees.

## **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.

## **Plan Administration and Contact Information**

Plan	Administered by	Contact Information	Insured by	Funded by
Medical Plan And Behavioral Health Plan	Blue Cross of Idaho Policy #: 10030497	3000 East Pine Avenue Meridian, ID 83642 1-866-685-2258 www.bcidaho.com	Self-insured	University and retiree contributions
Health Savings Accounts	HealthEquity (Please note: University's HSA provider – actual HSA provider for retirees can vary)	1-888-769-8696 www.Healthequity.com	Self-insured	Retiree contributions
Employee Assistance Plan	APS Healthcare	44 South Broadway Suite 1200 White Plains, NY 10601  1-800-999-1077 www.apshelplink.com (code UI1) www.apshealthcare.com to find providers	Self-insured	University contributions

Plan Administrator:	University of Idaho 415 West 6 <sup>th</sup> Street P.O. Box 444332 Moscow, ID 83844-4332 (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.