



BENELECT 2011

your guide to employee benefit options



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think beyond the possible™

BENELECT 2011

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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 CWRU. 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 our benefit carrier 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 choices. 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 or saving 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 premiums and/or spending or saving account deposits does 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, nonexempt or exempt status, and salary level.

- Full-time (100 percent): nonexempt employees working 37.5 hours per week or exempt and certain nonexempt employees working 40 hours per week
- Three-fourths-time (75 percent): nonexempt employees working 28-37.4 hours per week or exempt and certain nonexempt employees working 30-39.9 hours per week
- One-half-time (50 percent): nonexempt employees working 18.75-27.9 hours per week or exempt and certain 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)
- Children under age 26. For the Kaiser Permanente HMO medical option only, children between age 26 and age 28 are eligible for coverage if the child is: (1) unmarried; (2) a resident of Ohio or a full-time student attending school out-of-state; (3) not eligible for employer-sponsored coverage; and (4) not eligible for Medicare or Medicaid.
- Unmarried children of any age if they are mentally or physically incapable of supporting themselves

Documentation of a qualifying family member's relationship to an employee is required to substantiate eligibility for coverage. Proof of domestic partnership through notarized affidavit is required for spousal equivalent coverage. Children who have reached the end of their eligibility for coverage under Benelect are eligible for COBRA coverage if they are currently covered through Benelect. Detailed information can be obtained from Benefits Administration.

If you choose to cover your spouse or equivalent who has health insurance available through his/her employer, you will pay a surcharge for Benelect medical coverage.

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 (spouse/spouse equivalent)
- Birth or adoption of your child
- Death of your family members
- Change in your child's insurance status, i.e., gaining or losing coverage
- 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, dental and/or vision coverage

Benefit election changes made as a result of such changes in family or job status must be reported to Benefits Administration within 30 days of the qualifying life event along with appropriate documentation. Only election 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. Although you may change your level of coverage (category) if you meet the criteria, you may not change health coverage carriers.

FUTURE RETIREES

When you retire from CWRU, you can choose one of the medical plans

offered (Traditional through Medical Mutual of Ohio (MMO), Preferred Provider Organization (PPO) through Anthem, or Health Maintenance Organization (HMO) through Kaiser Permanente) and/or continue dental coverage that best fits your post-retirement needs. SuperMed Plus is only available if both the retiree and the covered spouse/equivalent are under age 65. A retiree may change plans at retirement only if their current plan does not provide in-network service in the area of their primary retirement residence. 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 annual open enrollment period unless a qualifying life event occurs.

Medical Coverage

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

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 drug benefit, convenience, low co-payments, no deductibles, and no claim forms.

MEDICAL MUTUAL OF OHIO 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 pharmacy benefit management (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.

ANTHEM BLUE CROSS AND BLUE SHIELD HIGH DEDUCTIBLE HEALTH PLAN

The High Deductible Health Plan (HDHP) and Health Savings Account (HSA) combine comprehensive medical coverage and a tax-advantaged savings account. The HDHP provides access to high quality health care through Anthem's provider network. The plan pays a large part of medical costs after the deductible is met and your expenses are limited by an annual out-of-pocket maximum. The HDHP does have a higher deductible; however, the deductible can be offset

by employee contributions to an HSA. Prescription coverage is through a separate PBM, carrier, CVS Caremark and your prescription costs are applied to your deductible. *You cannot participate in the health care flexible spending account under this option.* Instead, you have a different medical savings option available to you. The medical savings feature is a **Health Savings Account (HSA)**—an IRS-qualified feature that provides substantial tax savings and participant flexibility. The account is owned by the employee. This means that account balances roll over from year to year, even when you leave the university. The account has the flexibility to be used for current medical expenses or money can be left in the account to save for future health care expenses. Contributions, interest, and investment earnings are not subject to federal, state, or FICA taxes. You must be enrolled in the HDHP to contribute in an HSA. You cannot contribute to an HSA if you are enrolled in a medical plan that is not a high deductible plan. For example, if you are enrolled in Medicare, or

have secondary coverage through a spouse's plan, or your spouse has a medical flexible spending account that can be used to reimburse family member expenses, you may not be eligible to contribute to an HSA.

MEDICAL MUTUAL OF OHIO TRADITIONAL

The MMO Traditional plan is closed to new enrollment as of January 1, 2011. Current participants may continue in this option in 2011.

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 PBM carrier, CVS Caremark.

CVS CAREMARK PRESCRIPTION COVERAGE

Prescription coverage for all medical plans except Kaiser is through a separate PBM carrier, CVS Caremark. Registration on www.caremark.com will allow you to manage your prescription benefits and prescription history, access valuable health and wellness topics, and much more.

New for 2011 is Maintenance Choice, an option for those taking a long-term medication. Beginning January 1, you can choose to receive your 90-day supplies by mail or pick them up at a CVS/pharmacy near you. Whether you choose delivery or pick-up, you will pay the same co-payment.

If you are taking a long-term medication, the plan allows two 30-day fills for a low co-payment at any pharmacy in the CVS Caremark network. If you continue to get 30-day fills after that, you will pay a higher copay. With Maintenance Choice, you can avoid paying more for your long-term medication(s) by having 90-day supplies filled through the mail order pharmacy or at your local CVS pharmacy.

NO COVERAGE

If you already have medical coverage you may elect to waive 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:

- Employee
- Employee + Child(ren)
- Employee + Spouse (Equivalent)
- 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.

WORKING SPOUSE PREMIUM SURCHARGE

If your spouse or equivalent has access to a health plan through their employer, but you choose to cover her/him through Benelect, you will pay a premium surcharge.

MEDICAL PLAN OVERVIEW

Medical Plan Features	Anthem Blue Access PPO		MMO Traditional
	In-Network	Out-of-Network	
Primary Care Physician (PCP) Usual, Customary, and Reasonable (UCR) Fee Limits	Not required Yes	Not required Yes	Not required Yes
Annual Deductible <i>Individual</i> <i>Family</i>	None None	\$500 \$1,000	\$500 \$1,000
Annual Out-of-Pocket Limit <i>Individual</i> <i>Family</i> <i>After meeting annual limit</i> <i>Maximum Benefit</i>	None None --- Unlimited	\$1,500 (excluding deductible) \$3,000 (excluding deductible) 100% paid Unlimited	\$1,500 (excluding deductible) \$3,000 (excluding deductible) 100% paid Unlimited
Medical Necessity	Required	Required	Required
Medical Claim Forms	None	Required	Required
Hospital Services <i>Inpatient/Outpatient Care</i> <i>Emergency Care</i> <i>Urgent Care</i> <i>Pre-Certification</i>	\$250 per admission \$100 co-payment (waived if admitted) \$45 co-payment Provider handles	30/70% co-insurance after \$250 co-payment per admission & annual deductible \$100 co-payment (waived if admitted) \$45 co-payment Member must call	20/80% co-insurance 20/80% co-insurance 20/80% co-insurance Member must call
Physician Office Visits Specialty Care Visits Diagnostics Preventive Care Second Surgical Opinion	\$20 co-payment \$30 co-payment 100% paid 100% paid Voluntary	30/70% co-insurance after deductible 30/70% co-insurance after deductible 30/70% co-insurance after deductible 30/70% co-insurance after deductible Voluntary	20/80% co-insurance 20/80% co-insurance 20/80% co-insurance 100% paid Voluntary
Mental Health (MH) and Substance Abuse (SA) <i>Inpatient Hospital</i> <i>Outpatient Care</i> <i>Pre-certification</i>	\$250 per admission \$20 co-payment Provider handles	30/70% co-insurance after deductible 30/70% co-insurance after deductible Member must call	20/80% co-insurance 20/80% co-insurance Member must call
Prescription Drugs Retail Pharmacy (up to 30-day supply) Mail Service Pharmacy or CVS/pharmacy if through CVS Caremark (up to 90 day supply)	Through CVS Caremark: \$15 co-payment generic \$30 co-payment brand formulary \$60 co-payment non-formulary \$30 co-payment generic \$60 co-payment brand formulary \$120 co-payment non-formulary	No benefit from out-of- network pharmacy	Through CVS Caremark: No benefit from out-of- network pharmacy \$15 co-payment generic \$30 co-payment brand formulary \$60 co-payment non- formulary \$30 co-payment generic \$60 co-payment brand formulary \$120 co-payment non- formulary

(Effective January 1 through December 31, 2011) Refer to plan booklets for detailed coverage information

MMO SuperMed Plus PPO		Kaiser HMO	High Deductible Health Plan	
In-Network	Out-of-Network		In-Network	Out-of-Network
Not required Yes	Not required Yes	Required Yes	Not required Yes	Not required Yes
None None	\$500 \$1,000	None None	\$1,500 \$3,000	\$3,000 \$6,000
None None --- Unlimited Required None	\$1,500 (excluding deductible) \$3,000 (excluding deductible) 100% paid Unlimited Required Required	None None --- Unlimited Required None	\$1,500 (excluding deductible) \$3,000 (excluding deductible) 100% paid Unlimited Required Required	\$3,000 (excluding deductible) \$6,000 (excluding deductible) 100% paid Unlimited Required Required
\$250 per admission \$100 co-payment (waived if admitted) \$45 co-payment Provider handles	20/80% co-insurance after \$250 copayment per admission & annual deductible \$100 co-payment (waived if admitted) 20/80% co-insurance Member must call	100% paid \$100 co-payment (waived if admitted) \$45 co-payment Provider handles	20/80% co-insurance after deductible 20/80% co-insurance after deductible 20/80% co-insurance after deductible Provider handles	40/60% co-insurance after deductible 40/60% co-insurance after deductible 40/60% co-insurance after deductible Member must call
\$20 co-payment \$30 co-payment 100% paid 100% paid Voluntary	20/80% co-insurance 20/80% co-insurance 20/80% co-insurance 20/80% co-insurance Voluntary	\$20 co-payment \$30 co-payment 100% paid 100% paid Voluntary	20/80% co-insurance after deductible 20/80% co-insurance after deductible 20/80% co-insurance after deductible 100% paid Voluntary	40/60% co-insurance after deductible 40/60% co-insurance after deductible 40/60% co-insurance after deductible 40/60% co-insurance after deductible Voluntary
\$250 per admission \$20 co-payment Provider handles	20/80% co-insurance after \$250 copayment per admission & calendar year deductible 20/80% co-insurance Member must call	\$20 co-payment, group therapy \$10 co-payment \$20 co-payment Provider handles	20/80% co-insurance after deductible 20/80% co-insurance after deductible Provider handles	40/60% co-insurance after deductible 40/60% co-insurance after deductible Member must call
Through CVS Caremark: \$15 co-payment generic \$30 co-payment brand formulary \$60 co-payment non-formulary \$30 co-payment generic \$60 co-payment brand formulary \$120 co-payment non-formulary	No benefit from out-of-network pharmacy	Through Kaiser Pharmacy: No benefit from out-of-network pharmacy \$15 co-payment generic \$30 co-payment brand 60-day supply \$15 co-payment generic \$30 co-payment brand	Through CVS Caremark: Prescription drug costs count towards deductible. After deductible \$15 co-payment generic \$30 co-payment brand formulary \$60 co-payment non-formulary After deductible \$30 co-payment generic \$60 co-payment brand formulary \$120 co-payment non-formulary	Prescription drug costs count towards deductible. 40/60% co-insurance after deductible.

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. 2011 is a closed year for dental Open Enrollment. New hires may elect coverage upon hire, but the election is locked until the next open enrollment period for dental coverage.

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.

CASE SCHOOL OF DENTAL MEDICINE (SDM)

Case School of Dental Medicine offers 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. The care will be primarily provided by graduate dental practitioners at the School of Dental Medicine. Visit the School of Dental Medicine website at dental.case.edu/patients/employee.html for coverage details.

COVERAGE LEVEL

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

- Employee
- Employee + Child(ren)
- Employee + Spouse (Equivalent)
- Employee + Family

Basic Dental Features	DenteMax		Case School of Dental Medicine	
	In-Network	Out-of-Network	Basic	Comprehensive
Annual Deductible Individual Family	None None	\$50 for individual \$100 for family	None	None
Annual Maximum Benefit	\$1,500 per person	\$1,500 per person	See SDM website for details	See SDM website for details
Preventive Care Semi-annual exams and x-rays	100%	70% of UCR*	See SDM website for details	See SDM website for details
Basic Care Fillings, extractions, oral surgery, periodontia and endodontia	80%	60% of UCR*	Not covered	See SDM website for details
Major Care Bridgework, dentures, and crown restorations	60%	40% of UCR*	Not covered	See SDM website for details
Orthodontic Care Children under age 19 only after one year of participation (adult orthodontia is not covered)	50% \$1,250 lifetime benefit	35% of UCR \$800 lifetime benefit	Not covered	See SDM website for details
Refer to the plan booklets for detailed coverage information				

* Usual, Customary and Reasonable (UCR)

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. 2011 is a closed year for vision coverage open enrollment. New hires may elect coverage upon hire, but the election is locked until the next open enrollment period for vision coverage.

VISION SERVICE PLAN (VSP)

As the nation's pioneer and leader of vision care, VSP exceeds the standard in eye care by delivering exceptional value, service and providers. With VSP, you get private practice quality with retail choice and convenience for a one-stop-shop experience. With more than 39,000 access points nationwide, VSP neighborhood doctors take care of your eye care needs –including the latest eyewear fashions. Furthermore, 88% of VSP's network is open for early morning, evening and/or weekend appointments with 24-hour on-call availability.

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, ophthalmologists at University Hospitals Eye Institute and University Eye Care and Surgery, locations. The plan also provides for discounts of 25-45% off eyeglasses and 10-20% off contact lenses through network providers. Out of network benefit reimbursements are also available.

IN NETWORK	Vision Service Plan (VSP)		Union Eye Care	
	Frequency	Benefit	Frequency	Benefit
Routine Exam ■ Eyeglasses ■ Contacts	Every plan year	\$10 co-pay	Every plan year	\$10 co-pay at Union Eye Care facility \$25 co-pay at UH-Ophthalmology or UEC&S \$45 allowance
Prescription Glasses ■ Lenses (single vision, lined bifocal/ lined trifocal) (Polycarbonate lenses for dependent children) ■ Frames	Every plan year Every other plan year	\$25 co-pay \$120 allowance	Every plan year Every plan year	\$15 co-pay \$120 allowance
Contact Lens Care	Every plan year	\$120 allowance	Every plan year	\$120 allowance
OUT OF NETWORK ■ Exam ■ Lenses – Single Vision ■ Lenses – Bifocal ■ Lenses – Trifocal ■ Frame ■ Contact Lenses	Every plan year Every other plan year Every plan year	\$35 maximum \$25 maximum \$40 maximum \$55 maximum \$45 maximum \$105 maximum	Every plan year Every plan year	\$25 maximum \$25 maximum \$35 maximum \$45 maximum \$50 maximum \$60 maximum
COVERAGE LEVELS	■ Employee ■ Employee + child(ren) ■ Employee + spouse ■ Family		■ 1 Person ■ 2 Person ■ Family	
Additional information on the plans is available in the Benefits Office.				

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, you can purchase additional coverage based on multiples of your salary (one, one and one-half, two, two and one-half or three) or \$50,000. The cost of the additional coverage is based on your salary and age as of October 31 of the current year.

Your Age	Cost per \$1,000
Under 30	0.02
30-34	0.03
35-39	0.03
40-44	0.04
45-49	0.06
50-54	0.10
55-59	0.17
60-64	0.24
65-69	0.37
70 and over	0.73

The maximum amount of coverage available under Benelect is \$500,000. If you choose an amount greater than the \$20,000 basic coverage, 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 life insurance 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 approval notice from the provider.

New hires—Policies are guaranteed issued 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 if 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.

DISABILITY

Disability insurance 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!

Disability 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. Disability benefits are subject to offset for other sources of income and are taxable when paid to you.

SHORT-TERM DISABILITY COVERAGE (Exempt and Non-Exempt Staff [Cat. 2 & 3])

Short-term disability (STD) coverage provides you and your family with financial protection if you are temporarily unable to work as the result of a sickness or non-work related injury. Staff are eligible after 90 days of service. After 14 days of disability, STD pays 50 percent of salary up to a maximum of \$400 per week. The benefit covers up to 26 weeks of disability.

LONG-TERM DISABILITY COVERAGE (All Benefits Eligible Employees)

Long-term disability (LTD) coverage provides you and your family with financial protection if you are ever unable to work for an extended time period as the result of a sickness or injury. 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.

Age at Disability	Maximum Benefit Period
Less than age 60	To age 65 (but not 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 or over	12 months

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

You can make before-tax deposits to your health care 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 qualifying life event. The change in deposit amount must be consistent with the qualifying life event.

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 applicable law and the Benelect plan. Beginning January 1, 2011, over-the-counter drugs obtained without a prescription are not eligible for reimbursement.

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 have your claims for reimbursement processed.

Adopted in 2010 is a "grace period" for health care FSA expenses. The grace period is an extended period of coverage at the end of the plan year that allows you extra time to incur expenses to use your remaining Health Care FSA balance after the close of the plan year. The grace period's duration is two and one-half months. What this means for you is that you have until March 15, 2011 to incur expenses against your 2010 Health Care FSA, and you will need to submit a claim form to receive reimbursement. All claims submitted for services provided during the grace period will automatically be processed against the previous year's plan year first. If your claims exceed the available funds from the previous plan year, any excess will be automatically applied to your 2011 health care FSA election.

You will receive a Benny™ Prepaid Master Card® that can be used to pay for qualifying medical expenses. Although some of the expenses you incur can be automatically validated, this won't always be possible. In these instances, to comply with IRS regulations which govern the use of the card, you will receive a letter of notification asking you to furnish an itemized receipt to verify the expense. *When you receive such a request, make sure you submit the receipts as soon as possible to avoid having your card suspended until receipts have been submitted and approved.* Please note that if you use your debit card to pay for expenses during the FSA grace period (January 1 - March 15), the purchase will be applied towards your new plan year balance. FSA debit card purchases during the grace period cannot be used to access funds from the previous plan year.

ELIGIBLE HEALTH CARE EXPENSES

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

Flexible 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, flexible spending account balances do not earn interest.

DEPENDENT CARE FLEXIBLE 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 have your claims for reimbursement processed.

Adopted in 2010 is a "grace period" for dependent care FSA expenses. The grace period is an extended period of coverage at the end of the plan year that allows you extra time to incur expenses to use your remaining Dependent Care FSA balance after the close of the plan year. The grace period's duration is two and one-half months. What this means for you is that you have until March 15, 2011 to incur expenses against your 2010 Dependent Care FSA, and you will need to submit a claim form to receive reimbursement. All claims submitted for services provided during the grace period will automatically be processed against the previous year's plan year first. If your claims exceed the available funds from the previous plan year, any excess will be automatically applied to your 2011 dependent care FSA election.

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 con-

sistent with the documented qualifying life event. For more information, please refer to the summary of permissible life event changes in 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.

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.

DEPENDENT CARE SPENDING ACCOUNT WORKSHEET

This worksheet can help you estimate dependent care expenses for the upcoming year. Please consult a tax advisor to determine whether a Dependent Care FSA or tax credit is best for your personal circumstances.

Monthly Qualified Dependent Care Expenses

Baby sitter	\$ _____
Day care center	\$ _____
Nursery school	\$ _____
After-school care	\$ _____
Home health care worker	\$ _____
Care for eligible adult	\$ _____

Total Monthly Dependent Care Expenses \$ _____
 Multiply by 12 to calculate Annual Total \$ _____

Enter the monthly amount when making your benefit elections.

HEALTH CARE SPENDING ACCOUNT WORKSHEET

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

Eligible Medical Expenses	Estimated Annual
Deductibles	\$ _____
Co-payments	\$ _____
Co-insurance payments	\$ _____
Amounts above plan limits	\$ _____
Expenses not covered by your medical plan	\$ _____
Expenses not covered by your dental plan	\$ _____
Vision care (glasses, contact lenses)	\$ _____
Hearing care	\$ _____
Total Annual Health Care Expenses	\$ _____

OPTIONAL AFTER-TAX BENEFITS

Internal Revenue Service rules require you to use after-tax dollars to pay for these optional benefits. After-tax benefits are available through payroll deduction. Voluntary benefits generally are an annual enrollment, and can only be started or stopped each year during open enrollment (except for group auto and home, and long-term care).

DEPENDENT LIFE INSURANCE

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. Beginning January 1, 2011, coverage for dependent child(ren) ends at age 26.

PREPAID LEGAL

Hyatt Legal Plan 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 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.

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 your policy. Coverage begins and ends according to your individual policy.

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 your policy. Coverage begins and ends according to your individual policy.

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 forms and return them to Benefits Administration.

If you take no action in HCM during the open enrollment period, your 2011 Benelect elections will automatically default to the same coverage as in effect during 2010 which includes your flexible spending account contributions. Please take a moment to review your current elections before making your 2011 benefit coverage choices.

NEW HIRE ENROLLMENT

Use the enrollment form to make your elections by marking the options you want. Then sign and return the

form along with any relevant forms and documentation 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 on January 1 of 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

GLOSSARY OF TERMS

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986): 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 CWRU (and are paid once a month), you are paid to work 40 hours or more per workweek and are not eligible for overtime pay.

Flexible Spending Account (FSA): An FSA allows an employee to set aside a portion of his or her earnings to pay for qualified expenses. The Benelect plan includes a medical FSA (the health care flexible spending account) and a dependent care FSA (the dependent care flexible spending account). Money contributed to an FSA must be spent within the coverage period. Any money that is left unspent at the end of the coverage period is forfeited.

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.

Health Savings Account (HSA): A tax-advantaged medical savings account available to plan participants enrolled in a High Deductible Health Plan (HDHP) that allows an employee to set aside a portion of his or her earnings to pay for qualified expenses. The funds contributed to the account are not subject to federal income tax at the time of deposit. Unlike a flexible spending account (FSA), funds roll over and accumulate year to year if not spent. HSAs are owned by the individual.

High Deductible Health Plan (HDHP): A health insurance plan with lower premiums and higher deductibles than a traditional health plan. It is a form of catastrophic coverage.

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 CWRU 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 gate-keeper. 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.



Human Resources

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