Your benefits. Your choices.

Everyone is different and everyone’s needs are different. Benelect offers you the ability to choose the benefits that best meet your needs.

This year, there is a new carrier for our HMO plan. There are no other major changes to your benefit options. You can enroll in your 2017 benefits from November 7, 2016 through November 30, 2016. If you do not enroll, your 2017 benefits will default to the choices you made for this year.

Prepare for Open Enrollment by:
- Reviewing your 2016 benefit elections and noting how you and your family used health care and other benefits in 2016
- Understanding the impact Health Care Reform will have on the choices you’ll make
- Reading this Benelect Guide carefully
- Using the resources in this guide to get answers

Use PeopleSoft Human Capital Management (HCM) to enter your choices during open enrollment. Complete any additional enrollment forms needed and return them to Benefits Administration by December 5, 2016. **If you do not take action during the open enrollment period, your 2017 Benelect elections will automatically default to your 2016 coverage, including your flexible spending account contributions.**

Review your confirmation statement and address any inconsistencies or questions.

If you have concerns or questions as you review the information, contact the HR Customer Service Center at 216.368.6964 or visit hr.case.edu.

This Benelect Guide provides an overview of Benelect, the flexible benefits program offered by the university. It is not a comprehensive description of the benefit plans. Summary plan descriptions can be obtained from Benefits Administration.
HEALTH CARE REFORM

Since 2014, everyone is required to have health insurance. Health Care Reform enhances health insurance, and Case Western Reserve University’s plans meet all of the requirements to comply with the regulations. Health insurance plans offered through the university:

- Offer Essential Health Benefits
- Provide preventive care services at no cost to you
- Provide a minimum level of coverage
- Have no lifetime dollar caps on coverage
- Can include dependents up to age 26

If you can afford insurance but decide not to have coverage, you will pay a fine. In 2017 and beyond, the fine will remain 2.5% of your yearly family income, up to a set maximum. The maximum penalty for 2016 was $695 per person or $2,085 per family; the flat fee will be adjusted for inflation in 2017 and future years.

While the majority of people will get health insurance through work, there are options for those who don’t have employer-sponsored coverage. Individuals can go online to healthcare.gov to learn about the Individual Marketplace.

At the Marketplace, individuals can compare insurance plans and enroll in the plans that best meet their needs.

Some individuals may be eligible for tax credits or subsidies to reduce premiums and out-of-pocket costs. The amounts depend on income and family size. These financial aids are only available when insurance is purchased through the Marketplace.

Case Western Reserve University is committed to making sure you understand the implications of Health Care Reform. If you have questions on how these changes may impact you or your family, please contact the Human Resources Customer Service Center at 216.368.6964 or AskHR@case.edu.

Choose to Be Healthy

Don't take your health for granted. Getting healthy improves mental and physical well-being. CWRU offers several Wellness Programs to help you understand your current health, move toward healthier living and stay that way. You’ll find information at the back of this booklet, or online at case.edu/wellness.
Benelect, a flexible benefits program, offers you choices. You can choose the type of coverage you want and the family members you want to cover, or you can choose to waive coverage.

Choosing the benefits you need helps control the cost of benefits for you and the university. Choosing from a variety of benefit options also meets the diverse needs of staff and faculty.

Benelect provides tax savings. Paying for premiums with pre-tax payroll deductions and contributing to health care savings accounts saves money. Some benefits are paid using after-tax dollars and will continue to be deducted from net pay.

BENEFITS ELIGIBILITY

Open Enrollment
Your benefits begin January 1, 2017 and remain in effect for the whole calendar year.

New Hires
Benefits begin when employment starts 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 starts.

Domestic Partners
CWRU extends benefits to spouses and domestic partners (spouse equivalent).

You must document a qualifying member’s relationship to substantiate eligibility. Proof of domestic partnership through a notarized affidavit is required for spousal equivalent coverage.

NEW HIRE ENROLLMENT
Use the enrollment form to make your elections by marking the options you want. Return the form along with any relevant documentation to Benefits Administration within the first 30 days of employment. If you do not enroll within the first 30 days of 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.

PREMIUM COSTS
The university shares in the cost of your benefits. The amount depends on number of hours worked per week, coverage selected, exempt or non-exempt status and salary level. CWRU defines employees as:

- Full-time: non-exempt employees working 37.5 hours per week or exempt and certain non-exempt employees working 40 hours per week
- Three-fourths-time: non-exempt employees working 28–37.4 hours per week or exempt and certain nonexempt employees working 30–39.9 hours per week
- One-half-time: non-exempt 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 for you and for qualifying family members.

Qualifying family members are:
- Your spouse/spouse equivalent
- Children – refer to specific benefits section for age and other eligibility requirements

Children who have reached the end of their eligibility for coverage under Benelect are eligible for COBRA coverage if they currently are covered through Benelect.

Detailed information can be obtained from Benefits Administration.

FUTURE RETIREES
When you retire from CWRU, you can choose one of the medical plans offered and/or continue dental coverage that best fits your post-retirement needs. Retirees may change plans at retirement only if their current plan does not provide in-network service in the area of their primary retirement residence. Once you’ve retired, you can change medical or dental options only during the university’s annual open enrollment period, unless a qualifying life event occurs.

CHANGES DUE TO QUALIFYING 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, unless a Qualifying Life Event occurs during the 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

You must report changes to Benefits Administration within 30 days of the Qualifying Life Event. You must include appropriate documentation and the requested change must correspond with the change requested.

SPUSES BOTH WORKING AT CWRU
- Each spouse can select employee only, or
- One spouse can take employee + child(ren) and the other must select employee only, or
- One spouse can select family coverage and the other waive benefits coverage
Medical Coverage Highlights

PEACE OF MIND WHEN YOU NEED HEALTH CARE

Medical benefits provide you and your family with financial protection and access to quality health care. All Benelect medical insurance plans comply with Health Care Reform requirements. With Benelect, you can choose from several medical plans and coverage levels.

NO COVERAGE
If you already have medical coverage you may elect to waive coverage.

COVERAGE LEVELS
Once you choose the medical option that is right for you, you also choose the number of family members to cover. You may choose from these coverage categories:
- Employee
- Employee + Child(ren)
- Employee + Spouse/Spouse Equivalent
- Employee + Family

WORKING SPOUSE PREMIUM
If your spouse/equivalent has access to a health plan through his/her employer, but you choose to cover her/him through Benelect, you will pay an additional premium. The $100 per month premium offsets the university’s cost to provide health insurance to those spouses/equivalents who could obtain coverage from another employer. When you enroll your spouse or equivalent on your medical insurance, you will have the opportunity to waive the additional premium. If no election is made, the $100 monthly premium will be applied.

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.

As you begin to think about the best health insurance for you and your family, you should consider how the deductible and out-of-pocket expenses coordinate between family members.

High deductible plans include family deductible and family co-insurance limits. Each family member contributes to these limits. An individual can satisfy the family deductible and co-insurance limits.

PPO plans require that more than one family member contribute to meeting the family deductible and co-insurance limits. Medical co-payments and prescription co-payments accumulate toward out-of-pocket limits. Once the family deductible is met, co-insurance and co-payments will apply. The entire family will not incur charges over the deductible and out-of-pocket limits.
PRESCRIPTION DRUG COVERAGE

The CLE-Care HMO Plan includes prescription drug coverage through MetroHealth pharmacies.

CVS Caremark, a separate carrier, provides prescription drug coverage for all of the other medical plans offered.

Caremark is easy to use. Manage your prescription benefits and/or review your prescription history by logging on to caremark.com. You will also find health and wellness topics and updates.

Caremark also features Maintenance Choice for those taking long-term medications. In the short term, you can pick up two 30-day fills at any pharmacy. You can receive 90-day supplies by mail or pick up your medications at a CVS pharmacy near you. The same co-payment applies to either choice.

MEDICAL MUTUAL® OF OHIO CLE-CARE HEALTH MAINTENANCE ORGANIZATION (HMO)

NEW FOR 2017: When you elect this plan, you’ll get comprehensive health care services from a specified list of in-network providers. Your CLE-Care primary care physician (PCP) oversees your care, however no referrals are required when you see specialists within the MetroHealth System. The plan includes:

- Prescription drug coverage
- Low co-payments
- No deductibles
- No claim forms to complete

The CLE-Care HMO operates medical facilities throughout Cuyahoga County. Find a PCP by visiting metrohealth.org/doctor

MEDICAL MUTUAL® OF OHIO SUPERMED PLUS PPO

This PPO allows you full access to medical care from any physician or hospital in the Medical Mutual [SuperMed Plus] network with Medical Mutual of Ohio and MMO-affiliated networks out-of-state:

- You do not need to designate a primary care physician
- You do not need referrals for services
- You have coverage for medical emergencies in your area or when you travel
- Prescription drug coverage is available through a separate carrier, CVS Caremark

ANTHEM® BLUE CROSS AND BLUE SHIELD BLUE ACCESS PPO

In addition to the PPO features above, Anthem Blue Access PPO gives you access to the largest network of doctors and hospitals in Ohio, throughout the U.S. and even worldwide.

ANTHEM BLUE CROSS AND BLUE SHIELD HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

With the HDHP you get comprehensive medical coverage and can open a tax-advantaged savings account which can offset some of your medical costs. The HDHP provides access to high quality health care through Anthem's network of health care providers. The plan:

- Pays a large part of medical costs after the deductible is met
- Includes an out-of-pocket maximum amount
- Allows you to make pre-tax contributions to a Health Savings Account
- Offers prescription drug coverage through CVS Caremark
- Prescription costs apply to your deductible and out-of-pocket maximum amounts

Consider a Health Savings Account if you enroll in the Anthem Blue Cross and Blue Shield High Deductible Health Plan (HDHP).

Available only in conjunction with a high deductible health insurance plan, a Health Savings Account provides tax savings and flexibility.

- Contributions can be made on a pre-tax basis through payroll deduction
- You open the account, are responsible for contributions and direct any investment of the balance
- The account goes with you if you leave CWRU
- Balances roll over year to year
- Use the account to pay for current medical expenses or let the balance accumulate for future needs
- Contributions, interest and investments are not subject to federal, state, or FICA taxes

Find more information on Health Savings Accounts at hr.case.edu/benefits.
# Medical Plans Overview

Effective January 1 through December 31, 2017. Refer to plan booklets for detailed coverage information.

<table>
<thead>
<tr>
<th>Medical Plans Benefits</th>
<th>CLE-Care HMO*</th>
<th>Anthem High Deductible Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>Required</td>
<td>Not Required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>$1,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>$3,000**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$6,000**</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Limit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual (non-exempt or base salary &lt;$50,000/yr.)</td>
<td>$2,000</td>
<td>$3,000*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$6,000*</td>
</tr>
<tr>
<td>Individual (base salary ≥$50,000/yr.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family (non-exempt or base salary &lt;$50,000/yr.)</td>
<td>$6,000</td>
<td>$6,000**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$12,000**</td>
</tr>
<tr>
<td>Family (base salary ≥$50,000/yr.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>After Meeting Annual Maximum</strong></td>
<td>100% paid</td>
<td>100% paid</td>
</tr>
<tr>
<td></td>
<td>100% paid</td>
<td>100% paid</td>
</tr>
<tr>
<td><strong>Medical Claim Forms</strong></td>
<td>None</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient/Outpatient Care</td>
<td>100% paid</td>
<td>Co-insurance 40%*</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>$100 co-pay</td>
<td>Co-insurance 20%*</td>
</tr>
<tr>
<td></td>
<td>(waived if admitted)</td>
<td>Co-insurance 20%*</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$45 co-pay</td>
<td>Co-insurance 20%*</td>
</tr>
<tr>
<td>Pre-Certification</td>
<td>Provider handles</td>
<td>Provider handles</td>
</tr>
<tr>
<td></td>
<td>Provider handles</td>
<td>Member must call</td>
</tr>
<tr>
<td>Physician Office Visits</td>
<td>$15 co-pay</td>
<td>Co-insurance 20%*</td>
</tr>
<tr>
<td>Specialty Care Visits</td>
<td>$30 co-pay</td>
<td>Co-insurance 40%*</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>100% paid</td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100% paid</td>
<td>100% paid</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>100% paid</td>
<td>Co-insurance 20%*</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td>$15 co-pay;</td>
<td>Co-insurance 40%*</td>
</tr>
<tr>
<td></td>
<td>group therapy $5 co-pay</td>
<td>Provider handles</td>
</tr>
<tr>
<td>Pre-certification</td>
<td>Provider handles</td>
<td>Member must call</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>Provider handles</td>
<td>Prescription drug costs count toward deductible.</td>
</tr>
<tr>
<td>Retail Pharmacy (up to 30-day supply)</td>
<td>Through MetroHealth</td>
<td>Through CVS Caremark</td>
</tr>
<tr>
<td></td>
<td>$15 co-pay generic</td>
<td>After deductible:</td>
</tr>
<tr>
<td></td>
<td>$30 co-pay brand</td>
<td>$30 co-pay brand formulary</td>
</tr>
<tr>
<td>Other Retail Pharmacy</td>
<td>$25 co-pay generic</td>
<td>$60 co-pay non-formulary</td>
</tr>
<tr>
<td></td>
<td>$40 co-pay generic</td>
<td></td>
</tr>
<tr>
<td>Mail Service Pharmacy or CVS Caremark (up to 90-day supply)</td>
<td>Through MetroHealth Only:</td>
<td>After deductible:</td>
</tr>
<tr>
<td></td>
<td>90-day supply</td>
<td>$30 co-pay generic</td>
</tr>
<tr>
<td></td>
<td>$15 co-pay generic</td>
<td>$60 co-pay brand formulary</td>
</tr>
<tr>
<td></td>
<td>$30 co-pay brand</td>
<td>$120 co-pay non-formulary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After deductable:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$30 co-pay brand formulary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$120 co-pay non-formulary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After deductable:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Claim form must be submitted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Claim form must be submitted</td>
</tr>
</tbody>
</table>
## Medical Plans Overview

### Prescription Drugs
- Prescription drug costs count toward deductible.

### Mental Health and Substance Abuse
- None

### Hospital Services
- None
- Required

### Medical Claim Forms

<table>
<thead>
<tr>
<th></th>
<th>Annual Out-of-Pocket Limit</th>
<th>Annual Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>Principal Care Physician (PCP)</td>
<td>Required Not Required Not Required</td>
</tr>
</tbody>
</table>

### Medical Plans Benefits

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLE-Care HMO</td>
<td>Not Required</td>
<td>Not Required</td>
</tr>
<tr>
<td>CVS Caremark</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Mail Service Pharmacy or Retail Pharmacy</td>
<td>$500**</td>
<td>$1,000**</td>
</tr>
</tbody>
</table>

**Note:**
- $15 co-pay; (up to 90-day supply)
- $100 co-pay; (waived if admitted)
- $30 co-pay
group therapy $5 co-pay $120 co-pay non-formulary
- $60 co-pay brand formulary $30 co-pay
- $120 co-pay non-formulary

### Co-insurance

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLE-Care HMO</td>
<td>Co-insurance 20%*</td>
<td>Co-insurance 20%*</td>
</tr>
<tr>
<td>CVS Caremark</td>
<td>$100 co-pay (waived if admitted)</td>
<td>$100 co-pay (waived if admitted)</td>
</tr>
<tr>
<td>Mail Service Pharmacy or Retail Pharmacy</td>
<td>$100 co-pay (waived if admitted)</td>
<td>$100 co-pay (waived if admitted)</td>
</tr>
<tr>
<td>CVS Caremark</td>
<td>Co-insurance 20%*</td>
<td>Co-insurance 20%*</td>
</tr>
<tr>
<td>Mail Service Pharmacy or Retail Pharmacy</td>
<td>Co-insurance 20%*</td>
<td>Co-insurance 20%*</td>
</tr>
<tr>
<td>CVS Caremark</td>
<td>Provider handles</td>
<td>Provider handles</td>
</tr>
<tr>
<td>Mail Service Pharmacy or Retail Pharmacy</td>
<td>Provider handles</td>
<td>Provider handles</td>
</tr>
<tr>
<td>CVS Caremark</td>
<td>$20 co-pay</td>
<td>$20 co-pay</td>
</tr>
<tr>
<td>Mail Service Pharmacy or Retail Pharmacy</td>
<td>$20 co-pay</td>
<td>$20 co-pay</td>
</tr>
<tr>
<td>CVS Caremark</td>
<td>Co-insurance 20%*</td>
<td>Co-insurance 20%*</td>
</tr>
<tr>
<td>Mail Service Pharmacy or Retail Pharmacy</td>
<td>Co-insurance 20%*</td>
<td>Co-insurance 20%*</td>
</tr>
</tbody>
</table>

**Note:**
- Co-insurance begins after deductible is satisfied.
- The Annual Out-Of-Pocket Limit includes the deductible, all medical co-payments, and all prescription co-payments.

### Additional Information
- A CLE-Care HMO provider must be used to receive benefits.
- $3,500†
- $1,750†
- $2,000**
- $3,500**

### Family and Individual Limits

<table>
<thead>
<tr>
<th></th>
<th>Family</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limit for medical and prescription co-pays</td>
<td>$7,000**</td>
<td>$3,000**</td>
</tr>
<tr>
<td>Limit for medical and prescription co-pays</td>
<td>$6,000†**</td>
<td>$2,000†**</td>
</tr>
</tbody>
</table>

**Note:**
- Through CVS Caremark:
  - $15 co-pay generic
  - $30 co-pay brand formulary
  - $60 co-pay non-formulary

**Note:**
- $30 co-pay generic
- $60 co-pay brand formulary
- $120 co-pay non-formulary

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*See page 6 for additional information on how the deductible and out of pocket expenses coordinate between family members.*
Health Savings Account

CHOOSE TO SAVE MONEY

If you choose the Anthem Blue Cross and Blue Shield High Deductible Health Plan (HDHP), you can also contribute to a Health Savings Account on a pre-tax basis. The HSA is your account and can be used for medical expenses and to save for future medical expenses. The balances go with you should you leave the university.

When you open an HSA, you get all the conveniences of a bank account. You:
- Are the account owner
- Control the deposits and withdrawals from the account
- May also have the opportunity to invest the funds.
- May choose to use the funds for qualified medical expenses
- Take the balances with you when you change medical plans, change jobs or retire

You may want to use after-tax dollars for small expenses, saving the balances for larger or future medical needs. Like an IRA, an HSA has contribution limits for each tax year.

For 2017, you can contribute up to $3,400 for individuals with self-only coverage or $6,750 for family coverage.

Contributions are made through payroll deduction and the account is opened and serviced at BNY Mellon. Of course, you can open an HSA anywhere but you must use a BNY Mellon account to make HSA contributions via payroll deductions. Learn more at mybenefitwallet.com.

When you enroll in the HDHP, BNY Mellon will send you a new account welcome kit, including instructions for opening your HSA. You can activate the account at mybenefitwallet.com or call 1.877.472.4200 for assistance. You will receive a debit card once your signature card is returned to BNY Mellon.

The Internal Revenue Service governs HSA accounts and sets the contribution limits, eligibility requirements, qualified medical expenses and tax reporting rules. The IRS does not consider a domestic partner to be a spouse. However, if you are enrolled in a family HDHP that covers your domestic partner and your domestic partner satisfies the other HSA eligibility rules, the domestic partner may be able to establish and contribute to his/her own HSA. Consult with your personal tax advisor to assess the application of these rules to your personal tax situation.

The university will pay the account set-up fee and monthly maintenance fees during 2017 while you are actively employed at CWRU. You will pay any additional fees for the account, including check reorders and debit cards. IRS rules consider any banking fees deducted from your account to be allowable distributions. These charges are paid tax-free.
Dental Coverage

CHOOSE HEALTHY TEETH

Under Benelect, you can choose dental coverage through either DenteMax or the Case Western Reserve University School of Dental Medicine.

Dental coverage is available to:
- Employee
- Employee + Child(ren)
- Employee + Spouse/Equivalent
- Employee + Family

DENTE MAX
DenteMax is a dental PPO. 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. Find participating dentists at dentemax.com.

SCHOOL OF DENTAL MEDICINE
The School of Dental Medicine provides one dental benefit plan. The comprehensive plan offers a full range of services. In addition, value added services such as implants, tooth whitening, veneers and mouth guards are included at a 20% discount. See website for details.

Care is provided primarily by graduate dental practitioners at the School of Dental Medicine. Visit the School of Dental Medicine website at dental.case.edu/patients-clinics/employee/ for coverage details.

<table>
<thead>
<tr>
<th>Dental Plan Features</th>
<th>DenteMax</th>
<th>Case School of Dental Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Services</td>
<td>Services</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>In-Network</td>
<td>$50</td>
</tr>
<tr>
<td>Family</td>
<td>Out-of-Network</td>
<td>$100</td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>$1,500 per person</td>
<td>$1,500 per person</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>Semi-annual exams and x-rays</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>70% of UCR*</td>
</tr>
<tr>
<td><strong>Basic Care</strong></td>
<td>Fillings, extractions, oral surgery, periodontia and endodontia</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td>60% of UCR*</td>
</tr>
<tr>
<td></td>
<td>Simple restorative, simple extractions, emergency care</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Major Care</strong></td>
<td>Bridgework, dentures, and crown restorations</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td>40% of UCR*</td>
</tr>
<tr>
<td></td>
<td>Major restorative, fillings, bridgework, crowns, dentures and specialty care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Orthodontic Care</strong></td>
<td>Children under age 19 after one year of participation. Adult orthodontia is not covered.</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>35% of UCR</td>
<td>35% of UCR</td>
</tr>
<tr>
<td></td>
<td>$1,250 lifetime benefit</td>
<td>$900 lifetime benefit</td>
</tr>
<tr>
<td></td>
<td>$1,250 lifetime benefit</td>
<td>$900 lifetime benefit</td>
</tr>
</tbody>
</table>

*Usual, Customary and Reasonable Fees (UCR)

REFER TO THE PLAN BOOKLETS FOR DETAILED COVERAGE INFORMATION
Vision Coverage

CHOOSE TO SEE CLEARLY

Under Benelect, you can choose vision coverage through either Vision Service Plan (VSP) or Union Eye Care, Inc.

**VISION SERVICE PLAN (VSP)**

VSP provides private practice quality with retail choice and convenience at 39,000 locations nationwide. Nearly 90% 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 provides an annual eye examination, lenses and frames 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 allows discounts of 25-45% on eyeglasses and 10-20% on contact lenses through network providers. Out-of-network benefit reimbursements also are available.

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<table>
<thead>
<tr>
<th>Available Coverage Levels</th>
<th>Vision Service Plan (VSP)</th>
<th>Union Eye Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Benefit</td>
</tr>
<tr>
<td><strong>IN-NETWORK</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Exams</td>
<td>Employee; Employee + spouse; Employee + child(ren); Family</td>
<td></td>
</tr>
<tr>
<td>Eyeglasses</td>
<td>Every plan year</td>
<td>$10 co-pay</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>Every plan year</td>
<td>$10 co-pay</td>
</tr>
<tr>
<td>Prescription Lenses</td>
<td>$25 co-pay</td>
<td>$50 allowance</td>
</tr>
<tr>
<td>Lenses (single vision, lined bifocal/lined trifocal; Polycarbonate lenses for dependent children)</td>
<td>Every plan year</td>
<td>$25 co-pay</td>
</tr>
<tr>
<td>Frames</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td><strong>OUT-OF-NETWORK</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Exams (eyeglasses; contact lenses)</td>
<td>Every plan year</td>
<td>$50</td>
</tr>
<tr>
<td>Prescription Lenses</td>
<td>$50</td>
<td>$25</td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>$75</td>
<td>$35</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>$100</td>
<td>$50</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>$70</td>
<td>$50</td>
</tr>
<tr>
<td>Frame</td>
<td>$105</td>
<td>$50</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>$105</td>
<td>$50</td>
</tr>
</tbody>
</table>

Additional information on the plans is available in the Benefits Office.
Personal Life Insurance

CHOOSE TO PROTECT YOUR FINANCIAL SECURITY

Case Western Reserve University provides benefits-eligible faculty and staff with $20,000 term life and accidental death & dismemberment (AD&D) insurance at no cost to you.

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.

SUPPLEMENTAL LIFE INSURANCE
You can add to the basic $20,000 coverage provided by the university, based on multiples of your salary (1x, 1.5x, 2x, 2.5x or 3x) or you can add $30,000 of supplemental insurance so your total insurance amount equals $50,000.

You may want to consider the total amount of life insurance you need and then add coverage to get to that total. You pay only for coverage over $20,000.

Example: If you choose to have a total of $50,000 of life insurance, you pay for only the $30,000 of additional coverage. ($50,000 minus $20,000)

The cost of the additional coverage is based on your age as of October 31 of the current year.

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

The life insurance benefit is reduced by 35% at age 65, and further reduced to 50% of the original amount at age 70. Premiums reflect the reduced benefit amounts.

EVIDENCE OF INSURABILITY
If you want to increase your life insurance 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 coinciding with or the month following the date stated in the approval notice from the provider.

New hires—Policies are guarantee issued up to three times your salary.

NAMING A BENEFICIARY
You should have a beneficiary designation on file with Benefits Administration. Forms are available in Benefits Administration. 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. Consult your group insurance plan description for details.

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 insurance provides you and your family with important financial protection if you become disabled. This valuable benefit is at no cost to you.

Disability coverage is in addition to the university’s income protection plan, which allows staff members to draw from their sick leave balance up to a maximum of 26 weeks within any 12-month time period for personal medical leave, depending on the accrued balance. Disability benefits are subject to offset from other sources of income and are taxable when paid.

**SHORT-TERM DISABILITY COVERAGE**
(Exempt and Non-Exempt Staff [Cat. 2 & 3])
Short-term disability coverage provides you and your family with financial protection if you are temporarily unable to work as the result of an illness or non-work related injury. Staff are eligible after 90 days of service.

After 14 days of disability, this coverage pays 50% 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 coverage provides you with financial protection if you are ever unable to work for an extended time period as the result of an illness or injury.

If you are disabled for more than 180 days, you receive 60% of your pay, minus any primary Social Security payments, workers-compensation and other group long-term disability benefits.

The maximum monthly benefit is $6,000; the minimum monthly benefit is $100. Long-term disability payments continue until:
- Your disability ends
- Your death
- You begin working
- You attain age 65

Payments may continue beyond age 65 if you become disabled at age 60 or later.
Health Care Flexible Spending Account (FSA)

CHOOSE TO REIMBURSE YOURSELF

Case Western Reserve University offers Health Care Flexible Spending Accounts so you can save up to $2,600 in pre-tax dollars.

Plan your FSA contributions carefully. Your maximum annual contribution can’t exceed $2,600. Your deposit amount cannot be changed, stopped or started during the year, except if a Qualifying Life Event occurs. If dollars remain in the account at the end of the year or if the account terminates, balances in the account will be forfeited.

- The Health Care Flexible Spending Account reimburses you for certain medical care services, equipment and supplies
- Claims must total at least $50
- Insurance premiums cannot be reimbursed
- Over-the-counter drugs obtained without a prescription are not eligible for reimbursement
- You can be reimbursed for expenses incurred by legal dependents, but spouse-equivalent status is not recognized
- The account does not earn interest
- You have until June 30, 2018, to file claims for 2017

You will receive a Benny™ Prepaid Master Card® that can be used to pay for qualifying medical expenses. Some expenses will validate automatically. If this is not the case, you’ll receive a letter requesting itemized receipts per IRS regulations. Submit receipts as soon as possible to avoid card suspension.

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 & Co-payments
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 and television for a deaf person
Sterilization
Surgery
Therapy
Transplants
Vision care
Wheelchair
X-ray fees

GRACE PERIOD: The grace period is a two-month period of time at the end of the plan year that allows you extra time to incur expenses and use your remaining Health Care FSA balance. You will need to submit a claim form to receive reimbursement from your prior year FSA during the grace period. All claims submitted for services provided during the grace period will automatically be processed first against the previous year’s remaining balance. If your claims exceed the available funds from the previous plan year, any excess will be automatically applied to your current FSA election.

If you use your debit card to pay for expenses during the FSA grace period, the purchase will be applied toward your new plan year balance. FSA debit card purchases during the grace period cannot be charged to the balance from the previous plan year.
Dependent Care Flexible Spending Account

CHOOSE TO TAKE CARE OF OTHERS

The university offers an additional type of Flexible Spending Account where you can save up to $5,000 for the reimbursement of expenses incurred for the 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 $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
- Other qualifying family members who are physically or mentally incapable of caring for themselves and who qualify as dependents on your tax return

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. You have until June 30 of the following year to have claims for reimbursement for the prior year processed.

LIFE EVENT CHANGES

If your family or job status changes, for reasons specified in IRS regulations, you can start or stop a Dependent Care Spending Account, and under certain circumstances you can change the amount of the deposit. An account can be stopped or started, or the deposit amount can be changed only if the change is consistent with the 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. 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.

GRACE PERIOD: The grace period is a two-month period of time at the end of the plan year that allows you extra time to incur expenses and use your remaining Dependent Care FSA balance. You will need to submit a claim form to receive reimbursement from your prior year FSA during the grace period. All claims submitted for services provided during the grace period will automatically be processed first against the previous year’s remaining balance. If your claims exceed the available funds from the previous plan year, any excess will be automatically applied to your current FSA election.
Optional After-Tax Benefits

CHOOSE WHAT YOU NEED

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 can only be started or stopped each year during open enrollment (except for Group Auto and Home).

DEPENDENT LIFE INSURANCE
Dependent life insurance is a benefit that will be paid to you if your spouse/equivalent and/or child dies. The price for covering just a spouse (equivalent) or an entire family is the same. 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 Western Reserve University 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/equivalent 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.


Dependent life insurance for both children and spouse/equivalent are guarantee issued for new hires. Dependent life insurance added during open enrollment requires evidence of insurability for spouse/equivalent. The addition of dependent life insurance covering your spouse/equivalent will take effect on the first day of the policy month coinciding with or the month following the date stated in the approval notice from the provider.

PREPAID LEGAL

Hyatt Legal Plans offer representation for many personal legal services through the prepaid Legal Plan. Covered services include:
- Wills and estates
- Debt matters
- Injury and insurance
- Traffic
- Criminal
- Real estate

In addition, you may receive telephone advice and office consultations for virtually any personal legal matter. This gives you the opportunity to talk with an attorney about any personal legal issues 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 are required.

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 Auto & Home® 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.
Case Western Reserve University is committed to helping you find the resources you need to manage your health while taking the right steps to be as healthy as possible.

Making better choices in the food we eat, the activities we do and the lifestyles we live is easier than ever.

- The CWRU campus includes free fitness and recreational facilities, cafeterias with wholesome options, and classes and programs to increase awareness on the importance of good health.
- The Employee Assistance Service (ease@work) provides confidential counseling from a network of licensed and credentialed professionals.
- Our health plan carriers, Anthem and Medical Mutual, offer wellness programs, plans and tools on easily accessible websites.

NOTICE OF REASONABLE ALTERNATIVE STANDARD: If a medical condition makes it unreasonably difficult for you to achieve the standards for the incentive under this program, or if it is medically inadvisable as determined by your physician or health care provider for you to attempt to achieve the standards for the incentive under this program, contact erc10@case.edu to request a reasonable alternative standard, and we will work with you to provide another way to qualify for the incentive. Recommendations of your physician or health care provider will be considered and accommodated in developing an alternative standard that is reasonable in light of your health status.
PHYSICAL ACTIVITY

Campus Recreation Centers
Free use of the Veale Convocation, Recreation and Athletic Center and James C. Wyant Athletic Wellness Center for swimming, other cardiovascular workouts and strength training is available. Spouses/domestic partners may join the Veale Center for a $150 annual fee.

121 Fitness
Located on campus, this center offers a full range of fitness equipment and activities. Monthly fees are discounted if paid through payroll deduction. Call 216.368.1121.

Squire Valleeveue Farm
This Hunting Valley farm is used for scientific study, education and recreation for students and employees. Call 216.368.0275.

TOBACCO CESSATION
CWRU offers free tobacco cessation programs each quarter. Group programs are offered through ease@work. The QuitLine Program - Individual Coaching is also available for benefits-eligible faculty and staff. Additional information may be found at case.edu/wellness.

WEIGHT MANAGEMENT
Weight Watchers programs are offered on campus weekly. A 50% subsidy for Weight Watchers participants (at work and community meetings) is available for all benefits eligible faculty and staff. Additional information may be found at case.edu/wellness. Your medical plan may also include discounts for weight management programs.

WELLNESS PROGRAMS
Stress management, physical activity, nutrition, and financial well-being programs are offered on campus and online throughout the year for benefits-eligible employees. Additional information may be found at case.edu/wellness.
EMPLOYEE ASSISTANCE SERVICE
(ease@work)

When you face situations that are overwhelming, ease@work can help. You are eligible for three free visits per issue per year. You may be concerned about:

- Personal issues
- Depression
- Anxiety
- Marital matters
- Retirement
- Chemical dependency and abuse
- Parenting issues
- Divorce adjustment and options
- Work-related stress
- Legal and financial questions
- Nutrition and fitness
- Parenting issues
- Divorce adjustment and options
- Work-related stress
- Legal and financial questions
- Nutrition and fitness

Through more than 40 licensed, credentialed counseling professionals at more than 30 Northeast Ohio locations and as part of a national network, you will find the compassionate care and real answers you seek.

CHILD CARE

ease@work child care specialists have access to a database of child care provider resources links to community resources in and around your area. From infants to teens, ease@work can help you evaluate the quality of care and programs, address child development and parenting issues, and provide written information and practical tools such as booklets, checklists and guides. Referrals to community and nationwide services include:

- Day care centers
- Family day care home providers
- In-home providers
- Before and after-school programs
- Preschool/Headstart programs
- Summer programs
- Emergency/temporary/mildly sick care programs
- "Special needs" programs

OTHER EASE@WORK PROGRAMS

ease@work also offers nutrition and fitness counseling and other resources to help you live a healthy, balanced life.

Call 1.216.241.3273 or 1.800.521.3273 to be connected with ease@work. For more information, visit easeatwork.com.

CONDUCT YOUR OWN SEARCH FOR CHILDCARE

- Visit us at easeatwork.com/cust_resources/
- Enter ID Name: CWRU and Password: EASE
  Case sensitive, use all caps.
### SAMPLE WELLNESS OFFERINGS

<table>
<thead>
<tr>
<th></th>
<th><strong>Anthem</strong></th>
<th><strong>Medical Mutual</strong></th>
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<tbody>
<tr>
<td><strong>Website</strong></td>
<td>Anthem.com</td>
<td>MedMutual.com</td>
</tr>
<tr>
<td><strong>Mobile App</strong></td>
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<td>Yes</td>
</tr>
<tr>
<td><strong>Health Assessment</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Health Coach</strong></td>
<td>SelfHelp Works (discounted online coaching)</td>
<td>Yes (through disease and maternity management programs)</td>
</tr>
<tr>
<td><strong>Weight Management Discount</strong></td>
<td>Health Assistant Jenny Craig® Lindora®</td>
<td>Weight Watchers®</td>
</tr>
<tr>
<td><strong>Fitness Discount</strong></td>
<td>GlobalFit ChooseHealthy Performance Bicycle Linkwell</td>
<td>GlobalFit Curves</td>
</tr>
<tr>
<td><strong>Tobacco Cessation</strong></td>
<td>Health Assistant Selfhelpworks</td>
<td>SuperWell Quitline</td>
</tr>
<tr>
<td><strong>Disease/Chronic Condition/Maternity Management</strong></td>
<td>ConditionCare - focuses on 5 core chronic diseases</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>LiveHealthOnline (online physician visits)</td>
<td>MyCare Compare Interactive health education /health resource center</td>
</tr>
</tbody>
</table>
Special Enrollment Rights: If you decline enrollment for yourself, your spouse or your dependents in the medical, dental and vision plans because of other medical coverage, you may later be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 30 days after your prior coverage ends (or 60 days following loss of your prior coverage if your prior coverage is based on Medicaid or the Children’s Health Insurance Program). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days of the marriage, birth, adoption or placement for adoption.

Creditable Coverage: You should be provided with a certificate of creditable coverage, free of charge, from this plan via your health insurance issuer or administrator when you lose coverage under the plan; when you become entitled to COBRA; or when COBRA coverage ceases, if you request it before you lose coverage or if you request it up to 24 months after losing coverage.

Newborns’ and Mothers’ Health Protection Act: Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 as applicable).

Women’s Health and Cancer Rights Act of 1998: The Women’s Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. In the case of a plan participant who receives benefits in connection with a mastectomy, coverage will be provided in a manner determined in consultation with the attending physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of mastectomy, including lymphedemas.

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those established for other benefits under the plan.

HIPAA and Privacy Practices on Protected Health Information Notification of Availability: The Health Insurance Portability and Accountability Act (HIPAA) requires within the Standards for Privacy of Individually Identifiable Health Information (commonly known as the HIPAA Privacy Rule), a notice to be sent, which serves to inform you of the availability of the Notice of Privacy Practices for Case Western Reserve University Group Health Plan.

The Notice of Privacy Practices describes how protected health information may be used or disclosed by your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. The Notice also sets out our legal obligations concerning your protected health information, and describes your rights to access and control your protected health information. A copy of the Notice of Privacy Practices is available to all members of the Group Health Plan. You can obtain a copy of the Notice of Privacy Practices by:

- Picking up a paper copy in the Human Resources Department or;
- Contacting Benefits Administration at 216.368.6964 or visiting hr.case.edu/

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.

Any additional questions should be directed to:
Benefits Administration
Case Western Reserve University
320 Crawford Hall
10900 Euclid Avenue
Cleveland, OH 44106-7047
Phone: 216.368.6964, Fax: 216.368.3582.
GLOSSARY OF TERMS

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 a $20 co-payment for each doctor’s office visit, $250 for each stay in the hospital, and $15 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 its portion of covered expenses. For example, if the plan has a $500 deductible, the insured person would be responsible for the first $500 of his or her health care bills each year.

Domestic partner: see definition of spouse equivalent.

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

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.

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.

Preferred provider organization (PPO): Plan participants may seek care from an in-network provider or from an out-of-network provider, but the plan makes no provision to couple a patient with a primary-care physician or gatekeeper. Typically, the patient pays more for services from an out-of-network provider.

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.

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.

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).