Human Resources Contact Information

	Contact Phone Number
Employee Benefits	(210) 358-2324 (210) 358-2056 (210) 358-2230
Retirement	(210) 358-2072

Important Contact Information

Benefit	Contact	Phone Number/ Web Address	Important Information
Medical	CFHP Member Services (HMO) First Health (PPO) Prescriptions (NAVITUS)	(210) 358-6090 www.cfhp.com www.myfirsthealth.com (866) 333-2757 www.navitus.com	Group #004012-0004
Dental	Delta Guardian	(800) 521-2651 www.deltadentalins.com (888) 618-2016 www.GuardianAnytime.com	Group #5657-0002 Group #00439701
Vision	EyeMed Vision Care	(866) 299-1358 www.eyemedvisioncare.com	Group #9712944
Group Life Insurance	Reliance Standard	(800) 351-7500	Group #GL-668938
Dependent Group Life Insurance	Reliance Standard	(800) 351-7500	Group #GL-668938
Group Accident Hospital Income Plan	CFHP	(210) 358-2057	
Short-Term Disability	Reliance Standard/Matrix	(866) 533-3438	Group #VPS-671374
Long-Term Disability	Reliance Standard/Matrix	(866) 533-3438	Group #LTD-669900
Flexible Spending Accounts	Commerce Benefits Group	(800) 223-9941 www.commercebenefitsgroup.com	
Long Term Care	MedAmerica	(877) 340-7707	Group #5954
457 Retirement Savings	ING	(210) 979-8277 www.ingretirementplans.com	
457 Retirement Savings	VALIC	(210) 275-9118 (800) 448-2542 (210) 878-5402 www.valic.com	

This booklet is not a comprehensive description of plan benefits. For more detailed information, please refer to the plan documents available in Human Resources. You can find additional information in the legal documents that govern the Plans. University Health System reserves the right to amend, modify, or terminate any of the Plans in whole or part, at any time. The employee benefit programs are not, individually or collectively, an employment contract and do not give any employee any right to be retained in the services of the Health System. Contact the Human Resource Department for more information.

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University Health System Benefits

2013 Benefits Enrollment

As a resident of University Health System, you already know the importance of our medical benefits and the importance of networks in our industry. We want to renew our dedication to the needs of you and your family. As a part of our efforts to provide employee choice, while maintaining quality, cost-efficient healthcare benefits, we reviewed our healthcare networks and were able to provide you with a comprehensive medical plan to meet all your needs. The information included in this guide provides details about your options and instructions for using your benefits. Unless you have a qualifying change in status, your benefit elections will remain in effect for the 2013 calendar year. This guide does not provide comprehensive details about the benefit plans. If you have questions, dedicated Human Resources professionals are available to help you from 7:30 a.m. to 5 p.m., Monday through Friday.

Coverage Effective Dates

Your coverage under the University Health System Benefits Plan is effective as of your date of hire. **If you are enrolling in the Plan during open enrollment, your coverage is effective as of January 1.** If you or your dependents are enrolling due to a qualified status change, coverage will begin on the date of the qualifying event, unless stated differently in the plan documents.

Status Changes

Generally, once you enroll, you may not change your benefit elections until the next enrollment. However, you may be able to change your health plans during the year if you:

- Experience a no fault loss (or gain) of other health coverage.
- Have a change in status (non-funded to funded).

You may be able to change whom you cover if you have a qualifying change in status, such as:

- Marriage.
- Sign a Declaration and Registration of Informal Marriage filed through the County Clerk.
- Divorce, legal separation or annulment.
- Birth, adoption or placement for adoption.
- Legal guardianship.
- Death of a dependent.
- Ineligibility of a dependent due to age.
- Gain or loss of coverage by your spouse or other eligible dependent.

Human Resources must receive status change requests in writing within 31 days of the qualifying event. If your qualifying event results in dropping a dependent, and you do not notify Human Resource within 31 days, ineligible dependents will be dropped and any premiums for that dependent will not be refunded.

Dependent Verification

You must provide documentation for the dependent(s) you add to your plans. This documentation can be faxed to Human Resources at (210) 358-4765 or sent via inter-office mail to mail stop 99-1. You must write your name, employee ID number and phone number on each page you submit. If this documentation is not submitted by the deadline provided coverage for the dependent will be dropped as of the enrollment date. Please see below for a list of acceptable documentation.

For Your Spouse (please provide one of the following):
- Marriage License; or
- Church/Justice of the peace marriage certificate.

For Your Common Law Spouse:
- Declaration and Registration of Informal Marriage signed and filed through the County Clerk.

For Your Child (please provide one of the following):
- Birth Certificate identifying you as the parent; or
- Court Orders for adopted children or children placed for adoption; or
- Court Orders giving you legal guardianship for court appointed children; or
- Documentation on hospital letterhead indicating birth date of child and identifying you as the parent, or
- Qualified Medical Child Support Order (QMSCO).

For Your Stepchild (please provide one of the following):
- Birth Certificate identifying your spouse as the parent, or
- Documentation on hospital letterhead indicating birth date of child and identifying your spouse as the parent.

Plus documentation showing your relationship to the stepchild's parent such as:

- Marriage License; or
- Church/Justice of the peace marriage certificate; or
- Declaration and Registration of Informal Marriage signed and filed through the County Clerk.

For Your Grandchild:
- Court Orders giving you legal guardianship.

If you leave University Health System

The medical, dental, and vision coverages will extend through the last day of the month you terminate employment with University Health System, all other benefits will terminate on your last day worked. However, you have the right to temporarily extend some of your coverages under certain circumstances. Contact the Human Resources Department for further information on the extension provisions.

Medical

As one of the top providers of health care in the country, University Health System recognizes the importance of having medical insurance. That is why it is a condition of employment to carry medical insurance, whether through University Health System or through an outside carrier. If an election is not made within your first 30 days of employment, you will be defaulted into Resident only status under the University Family Care Plan.

University Health System offers a comprehensive medical plan administered by Community First Health Plans called the University Family Care Plan.

The plan provisions allow each resident and their family to receive a high level of care without being subjected to a waiting period for pre-existing conditions. You and the Health System share the cost of medical coverage. Costs vary by the level of coverage that you select.

The plan includes:

- Comprehensive eye exams provided by OptiCare.
- Prescription drug coverage.
- Self-referrals to participating Obstetricians/Gynecologists (OB/GYN).

University Family Care Plan

The University Family Care Plan includes two networks. You can choose to receive services from inside and outside the University Health System family of providers for your health care needs.

The two networks are the University Health System Family network, which will continue to provide the high level of medical care that you and your family have come to know, and the First Health network, which will allow you the flexibility to choose providers outside of the University Health System Family network under a PPO payment schedule.

University Health System Family network – will continue to provide service exclusively from Community Medicine Associates (CMA) physicians, UT Medicine San Antonio and certain other designated providers and facilities. If you choose to utilize the University Health System Family network you will continue to enjoy immense cost savings through set co-payment amounts, no co-insurance and no annual deductibles.

First Health network – will provide you with the opportunity to seek treatment from physicians and facilities outside of the University Health System family. However, when utilizing these services the claims will be subject to a PPO payment schedule meaning they will be subject to an annual deductible and co-insurance for all services.

Primary Care Physician

You are required to choose a Primary Care Physician (PCP) to coordinate your care under the University Health System Family network. Please indicate your PCP election by providing the PCP number, from the provider directory, on your enrollment form.

University Family Care Plan

Coverage Category	Resident Monthly Premium
Resident	$53.58/month
Resident & spouse	$95.03/month
Resident & child(ren)	$93.52/month
Resident & family	$160.92/month

Medical Benefit Summary

Features	University Family Care Plan UHS Family Network	 First Health Network
Annual Deductible Individual/Family	None	$500/$1,000
Out-of-Pocket Maximum (after deductible) Individual/Family	None	$4,000/$8,000
Medical Care Physician's office, including prenatal care	$15 per visit	70% is covered after deductible
Preventive Care Services Well baby care (under age two) & Physical exams (annually) Pediatric & Adult Immunizations / Mammography Services	 *No Co-payment *No Co-payment	 *No out of pocket costs *No out of pocket costs
Prescribed Medical Services and Supplies Radiation Therapy & Lab Tests Durable Medical Equipment ($2,000 annual limit)	 No Co-payment No Co-payment	 70% is covered after deductible 70% is covered after deductible
Hospital Inpatient (pre-authorization required) All inpatient covered services and supplies, ICU, oxygen, hospital ancillary charges (excludes mental health) Physicians' charges, including surgery	 $100/day; $500 max/confinement No Co-payment	 70% is covered after deductible 70% is covered after deductible
Outpatient Surgery (pre-authorization required) Services supplied in connection with surgery Outpatient surgery facility charge	 No Co-payment $100/visit	 70% is covered after deductible 70% is covered after deductible
Mental Health Services Acute inpatient covered services supplies for the treatment of serious mental illness, residential treatment center for children and adolescents, crisis stabilization unit Outpatient visits for crisis intervention and evaluation Outpatient visits for serious mental illness	 $100/day; $500 max/confinement $15 per visit $15 per visit	 70% is covered after deductible 70% is covered after deductible 70% is covered after deductible
Alcoholism and Chemical Dependency All medically necessary outpatient covered services both Inpatient & Outpatient	 $100/day; $500 max/confinement $15 per visit	 70% is covered after deductible 70% is covered after deductible
Skilled Nursing Facility Up to 60 days per condition/year including semi-private room, lab and X-ray	$15 per day	70% is covered after deductible (Lifetime maximum $10,000)
Home Health Care Part-time or intermittent	No Co-payment	70% is covered after deductible (Lifetime maximum $10,000)
Hospice	No Co-payment	70% is covered after deductible (Lifetime maximum $10,000)
Medical Transportation Ambulance services when medically necessary	$100 per use	70% is covered after deductible
Urgent Care	$15 per visit	70% is covered after deductible
Emergency Room - waived if admitted	$100 per visit	$100 per visit
Prescription Drugs Generic Drugs Preferred Brand Drugs Non-preferred Drugs	 $10 (30 day) $20 (90 day) $20 (30 day) $40 (90 day) $40 (30 day) $80 (90 day)	 $10 (30 day) $20 (90 day) $20 (30 day) $40 (90 day) $40 (30 day) $80 (90 day)
University Health System Rx Mail-order Service Maintenance drug refills	No Co-payment* *Prescription must be written by a University Health System, CMA, or UT Medicine San Antonio physician	No Co-payment*

*Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

PPO Network

PPO providers agree to charge no more than reasonable, predetermined discounted fees for their services. To find out if a specific doctor is in the First Health PPO network check the on-line provider directory at www.myfirsthealth.com or contact CFHP Member Services at 358-6090.

Family Link

Available 24 hours a day, 7 days a week, Family Link will assist you with routine and referral appointments, health information or nurse advice for symptom-based questions, and access to University Health System pharmacies.

Family Link is your access to healthcare. There is only one number you need to remember: 358-6090.

Payroll Co-payment Deductions for Medical Services

For your convenience, Medical Services co-payments for you or your dependents may be automatically payroll deducted. All co-pays not paid for at time of service or discharge for you or your dependents **will** be automatically deducted.

Definitions

Annual Deductible
The amount you must pay before the Plan begins paying benefits.

Annual Out-of-Pocket Maximum
The limit on the amount of medical expenses you pay in a calendar year. The out-of-pocket maximum does not include your deductible or any charges over allowable charges, co-payments or charges that are ineligible expenses under the Plan.

Co-insurance
The percentage of cost associated with the medical services paid by you. The co-insurance is 30 percent of the medical service cost after the deductible and co-payment up to the annual out-of-pocket maximum.

Co-payment
A set fee that you pay for medical services, such as $15 for an office visit to your primary care doctor, when using the University Health System network. After your co-payment, the Plan generally pays 100 percent of covered expenses. Co-payments do not count toward the accumulation of your deductibles or out-of-pocket maximums.

Medical Emergency
A sickness or injury in which failure to get immediate medical care could seriously threaten your life or health. Examples of medical emergencies include apparent heart attack, obvious fractures and deep cuts requiring immediate medical attention.

Primary Care Physician (PCP)
The provider who acts as your primary physician and may refer you to specialists. Your PCP can be a family practitioner, general practitioner, internal medicine physician or pediatrician.

Prescription Drug Features

If you enroll in medical coverage, your prescription drug coverage is provided and managed by Navitus through Community First Health Plans (CFHP). The Prescription Drug Program provides benefits for both short-term and long-term medication. For more information regarding limitations on prescriptions please consult the Preferred Drug Listing provided with your enrollment materials or on the University Health System intranet site under the Rx & Go Program link. You are encouraged, but not required, to use the mail-order drug program for long-term maintenance prescriptions.

Payroll Co-payment Deductions for Prescription Services

For your convenience, co-payments will be automatically payroll deducted when prescriptions are processed through the University Health System pharmacy for you or your dependents.

Retail Pharmacy Access:

Through the Prescription Drug Program you have access to a large number of retail pharmacies. You and your family can utilize a retail pharmacy when filling a prescription at anytime. Prescriptions that should always be taken to a retail pharmacy include:

- Any medication not listed in the Formulary Drug List unless otherwise noted.
- Immediate needs or emergency medications.
- Prescriptions needed after University Health System lobby pharmacy hours, on weekends or holidays.
- Prescriptions written by providers outside of the CMA/UT Medicine San Antonio provider group.

How to Receive Mail Order Medication:

Use this option if your medication has a Mail Box symbol next to the drug name on the Preferred Drug List and you wish to have your medications mailed to you.

- Fill out Prescription Mail-Out Request Form completely (include allergy information and CFHP member ID), then sign it.
- If you have new prescriptions, attach them to the completed form, then place the form into the Employee Prescription Drop-Off Slot at the University Health System pharmacy of your choice.
- If you have ONLY refills or transfers : FAX to (210) 358-9650 or place the form in the Employee Prescription Drop-Off Slot at the University Health System pharmacy of your choice.

Pick up at University Health System Pharmacy:

Use this option if your medication does NOT have a Mail Box symbol next to the drug name on the Preferred Drug List and you wish to pick up your prescriptions at a University Health System pharmacy.

- Fill out Prescription Pick Up Request Form completely (include allergy information and CFHP member ID), then sign it.
- If you have new prescriptions, attach them to the completed form and place the form in the Employee Prescription Drop-Off Slot at the University Health System pharmacy of your choice.
- If you have ONLY refills or transfers: FAX to (210) 358-9996 or place the form in the Employee Prescription Drop-Off Slot at the University Health System pharmacy of your choice.

When utilizing the University Health System family of pharmacies it is important to follow the drop-off and pick-up times when getting your prescription(s) filled. The night pharmacy will not service this program. Drop off at the designated Employee Prescription Drop-Off Slot, Monday–Friday 9:30 a.m. - 4 p.m., at any of the University Health System outpatient pharmacies through the designated mail slots. Pick up your order at the Employee Service Window (or other designated area), Monday–Friday only.

- 2 - 4 p.m. if dropped off before 11 a.m. the same day.
- 9:30 - 11:30 a.m. the next day if dropped off after 11 a.m.

Some prescriptions may require 2 business days to process if the medication is not routinely stocked. If you need your prescription filled immediately, you should continue to use an outside pharmacy of your choice.

Dental

University Health System offers two dental plan options. Each plan has separate rates.

Option I — Delta Dental

The Delta Dental PPO allows you the freedom to see any dentist that you would like nationwide. When you are covered under the PPO plan, you and your family members can change dentists at any time without notifying the carrier. Delta Dental dentists will also file claim forms for you and accept payment directly from Delta Dental. The services listed below are covered when performed by a licensed Delta dentist.

To locate an in-network dentist, visit www.deltadentalins.com or call 1-800-521-2651.

TYPE OF BENEFIT	DENTAL BENEFITS
Maximum Benefit Per Calendar Year: Applies to all services except Orthodontic Treatment	$1,000
Lifetime Maximum Benefit For Orthodontic Treatment	$1,500
Deductible Per Calendar Year:	
Per Covered Person:	
Preventive and Diagnostic Services:	Waived
Basic, Restorative and Major Services Combined:	$50
Family Deductible Limit:	
Preventive and Diagnostic Services:	Waived
Basic, Restorative and Major Services Combined:	$100
Lifetime Deductible for Orthodontic Treatment:	
Per Covered Person	$50
Per Covered Family	$100
Benefit Percentage (payable by the plan):	
Preventive and Diagnostic Services	100%
Basic and Restorative Services	80%
Major Services	50%
Orthodontic Treatment	50%
NOTE: Orthodontic benefits are available for dependent children only.	

Please refer to the Plan Document for clarifications, limitations and exclusions and covered expenses not addressed in this Summary of Dental Benefits.

Coverage Category	Resident Monthly Premium
Resident	$11.79/month
Resident & spouse	$32.92/month
Resident & child(ren)	$44.40/month
Resident & family	$57.98/month

Option II — Guardian Dental

The second dental option is Guardian Dental HMO. Guardian allows you to select a general dentist from their provider network. Your primary general dentist will then refer you to a specialist for extended care.

This plan not only covers preventive care, restorative care, and periodontics, but also covers adult and child orthodontics without deductibles, co-insurance or maximums. There is a $5 co-payment for office visits.

To locate a Guardian provider, visit www.GuardianAnytime.com or call 1-888-618-2016.

TYPE OF BENEFIT	YOU PAY
Anesthesia (Local)*	$0
Bridges and Dentures	$260
Cleaning (prophylaxis) Frequency	$0 2 in 12 Months
Fillings (one surface)	$0
Fluoride Treatments Limits	$0 Under Age 18
Oral Exams	$0
Orthodontia Limits (Treatment in progress is not covered)	$2,285 Adults & Child(ren)
Perio Surgery	$290
Periodontal Maintenance Frequency	$35 Once every 3 to 6 months
Repair & Maintenance of Crowns, Bridges and Dentures	$85 - $100
Root Canal	$90 - $230
Scaling & Root Planing (per quadrant)	$45
Sealants (per tooth)	$10
Simple Extractions	$0
Single Crowns	$280
Surgical Extractions	$25 - $75
X-rays	$0

This is only a partial list of dental services and fees when utilizing a network provider. Your certificate of benefits will show exactly what is covered and excluded.

Coverage Category	Resident Monthly Premium
Resident	$5.60/month
Resident & spouse	$14.69/month
Resident & child(ren)	$20.18/month
Resident & family	$24.28/month

Vision

EyeMed Vision Care

Regular examinations from an eye care professional not only ensures healthy vision, but can lead to overall good health. That is why University Health System offers comprehensive vision coverage through EyeMed Vision Care. EyeMed provides benefits for eye exams and your choice of frames and lenses, or contacts.

To locate a participating provider, visit www.eyemedvisioncare.com or call 1-866-299-1358.

VISION CARE SERVICES*	IN-NETWORK MEMBER COST
Exam with Dilation as Necessary	$20 Copay
Contact Lens Fit and Follow-up: (Contact lens fit and follow-up visits are available once a comprehensive eye exam has been completed.)	
Standard	Up to $40
Premium	10% off retail price
Frames:	$0 Copay, $140 allowance; 20% off balance over $140
Standard Plastic Lenses:	
Single Vision	$20 Copay
Bifocal	$20 Copay
Trifocal	$20 Copay
Progressive	$20 Copay
Lenticular	$20 Copay
Contact Lenses (allowance covers materials only):	
Conventional	$0 Copay, $140 allowance; 15% off balance over $140
Disposables	$0 Copay, $140 allowance; plus balance over $140
Medically Necessary	$0 Copay, Paid in Full
LASIK and PRK Vision Correction Procedures:	15% off retail price or 5% off promotional pricing

*Partial Listing

Covered Service	Frequency
Exam	Once every 12 months
Frames	Once every 24 months
Standard Plastic Lenses or Contact Lenses	Once every 12 months

Coverage Category	Resident Monthly Premium
Resident	$4.99/month
Resident & spouse	$9.49/month
Resident & child(ren)	$9.99/month
Resident & family	$14.68/month

Life Insurance

Group Term Life and Accidental Death and Dismemberment Insurance

University Health System provides Group Term Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance to all University Health System funded House Staff members at no cost.

Group Term Life Insurance and AD&D Insurance cover you on or off the job. Dependents are not covered under this policy. The amount of your Group Term Life coverage is $25,000 subject to applicable age reductions for eligible employees age 65 and over according to the schedule in the policy. If you should become disabled prior to age 60, premiums for life insurance can be waived after a six-month disability. At the end of your employment, a conversion option is available.

Dependent Group Life

Life insurance coverage is available to purchase for your spouse and/or child(ren) at a minimal cost.

Dependent Coverage	Monthly Premium
$10,000/Spouse $5,000/Child	$0.70
$20,000/Spouse $10,000/Child	$1.40

Beneficiary Designation

You may name anyone as your beneficiary by completing the beneficiary section during online enrollment or on your Benefit Election Form. You may change your beneficiary at any time. If you name more than one primary beneficiary, they will share equally unless you indicate otherwise.

Disability

Short-Term/Long-Term Disability Insurance

Short-Term and Long-Term Disability Insurance is provided to each eligible House Staff member at no charge. Disability insurance is provided for non-work related injuries or illness. Short-term disability coverage will provide you with 70 percent of your weekly salary after a 30-day waiting period. Short-term disability is for any illness or injury you may experience, including pregnancy, HIV, HBV, AIDS, latex allergies, etc. After 90 days of illness
or injury, the long-term disability benefit becomes effective. Long-term disability is provided to you at a coverage level of $2,000 per month. Work-related illnesses and injuries are covered under Workers' Compensation coverage.

Evidence of Insurability (EOI)

The EOI process is the means by which our insurance carrier defines you or your family's level of insurability. The EOI is a request for health information and is required when applying for some of the life and disability products offered by University Health System. When an EOI is required the independent underwriters must approve coverage for a resident and/or dependent(s). The approval process begins when you complete and return an EOI form. The carrier may require additional information after reviewing your EOI form, and may deny coverage if your health status does not meet underwriting guidelines.

Flexible Spending Accounts

University Health System provides an opportunity to participate in two types of flexible spending accounts (FSAs) — a Health Care FSA and a Dependent Care FSA. You may elect to participate in one or both of these accounts. The accounts allow you to set aside money on a pre-tax basis to reimburse yourself for eligible health and dependent care expenses. You save money by not paying taxes on the amount you set aside. You must re-elect this coverage every year during annual enrollment. Coverage is not automatic and will not roll over from year-to-year.

FSA Frequently Asked Questions

How much should I contribute?
The amount you choose to contribute will vary based on your individual needs. You should consider the amount you contribute into each account carefully. If you do not use all of the money in your accounts during the plan year you will forfeit the remaining balance per IRS regulations.

How long do I have to use the money in my FSAs?
Your expenses must be incurred by March 15, 2014. You have 90 days after the end of the year extension (by June 15, 2014) to request reimbursement for expenses incurred during the election period. You may not transfer money between the accounts or carry a balance over to the next enrollment period due to IRS regulations. If you are hired anytime during the year, the amount you elect will be taken during the remaining months in that calendar year.

Can I change the amount I've elected to contribute?
Once you decide how much to put into a flexible spending account, your election will remain in effect for the entire plan year – unless you have a qualifying change in status and the change to your election is consistent with the status change.

What happens if I terminate my employment?
If you terminate employment, you will be allowed to continue participating in the Flexible Spending Account following the guidelines of COBRA; however, contributions for continuation of coverage will be on an after-tax basis. If you choose not to continue coverage and have a balance remaining in your account, you may submit claims incurred during the plan year, but not later than your termination date. Claims may be submitted up to 90 days after your termination.

Health Care Flexible Spending Account

The Health Care Flexible Spending Account exists to help you pay for health care expenses that are medically necessary, non-cosmetic in nature and not fully covered under your medical or dental plan. The maximum amount you can deposit into this account in 2013 is $2,500.

You do not have to be enrolled in the Health System's medical plan to have eligible expenses. To receive reimbursement, you must submit a claim and receipt for services. Reimbursements are processed weekly and can be mailed to your home address or direct deposited into your bank account.

Typical expenses that are reimbursed are deductibles, co-insurances, braces, hearing aids etc.

Please be advised that effective January 1, 2011 over the counter medications are no longer reimbursable under the Health Care FSA.

PARTIAL LISTING OF ELIGIBLE MEDICAL EXPENSES

GENERAL MEDICAL EXPENSES

- Acupuncture
- Anesthesia
- Artificial Limbs/Prosthesis
- Back Supports
- Blood Donor Expenses
- Braces
- Co-payments you pay
- Deductibles
- Dermatologist Fees
- Doctors Office Visits
- Drug Treatment
- Gynecological Exams
- Hospital Bills
- Immunizations
- Insulin
- Lab Expenses
- Medical Equipment / Supplies
- Neurologist Fees
- Orthopedic Shoes
- Physical Therapy
- Physician Fees
- Physical Exams
- Prescription Drugs (**Drug name required**)
- Psychiatric Care
- Smoking Cessation Program
- Special Diets if not a substitute for a regular diet
- Wheelchair

DENTAL EXPENSES

Bridges, Crowns, Dentures, Exams, Fillings, Orthodontia, X-rays, Insurance Deductible, Co-payments you pay

HEARING EXPENSES

Exams, Hearing Devices and Aids (including batteries)
Special Communication Equipment for the Deaf

VISION CARE

Exams, Contact Lenses, Frames, Lenses, Solutions, Oculist Services, Optician Services, Optometrist Services, Radial Keratotomy, Lasik Eye Surgery

Important: Consult IRS publication 502 for a more complete listing of eligible and non-eligible medical expenses

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account exists to help you pay for dependent care expenses for your children under age 13 or adult family members who are disabled and depend on you for support. If dependent care is required to enable you (and your spouse, if married) to work, these expenses may be eligible for reimbursement. Included are payments to child care centers, nursery schools, kindergarten and schools for children up to but not including first grade. Eligible expenses also include payment for summer day camps, after school care and elder care. Care within your home by a relative, or a non-relative, as long as such person is reporting payments as income, is also eligible. The maximum amount you can deposit in 2013 is $5,000, or $2,500 if you are married, but filing separately.

Any eligible dependent care expenses are reimbursable through the Dependent Care Flexible Spending Account by filing a reimbursement account claim form with Commerce Benefits Group.

Important Restrictions:
If married, the total payments made in a taxable year, under this and any other dependent care plan, cannot exceed the lesser of your earned income, or your spouse's earned income during that taxable year. The expenses must be necessary to enable you (and your spouse, if married) to work or actively search for employment. Your spouse must work outside the home, be a full-time student or be disabled. Eligible dependents must be under the age of 13 and must be eligible to be claimed as a dependent on your federal income tax return, or your dependent is physically or mentally incapable of caring for himself or herself (a disabled spouse or elderly parent, for example). If services were provided outside the home, the dependent for which service is incurred must spend at least eight hours per day in your household. In addition, the person providing the service can not be claimed as a dependent on your income tax return for the plan year in which the service was provided.

Comparison to Tax Credits:
Taking the tax credit on your federal income tax return (and state income tax return, if applicable) may be more tax favorable than using the Dependent Care FSA. The best option for you depends on your annual income, amount of dependent care expenses and other circumstances. In some cases, a combination of the Dependent Care FSA and use of the tax credit may be best for you. In all cases, you should consult a qualified tax advisor to determine which of these and other tax options, including other tax credit options, are better for you. This information is provided for general guidelines only, and is not intended to be tax advice.

Use It or Lose It

If you do not use all of the money in your accounts during the plan year or extension period and do not file for reimbursement by June 15 of the following year, you will forfeit the remaining balance. This is an IRS rule.

IRS Regulation

IRS regulations state that you may not be reimbursed for day care expenses if you are off work due to illness or on a leave of absence. See IRS publication 503 at www.irs.gov for more information.

Payroll Deducted Co-pays

Please remember you cannot claim your payroll deducted co-payments under your FSA. Your payroll deducted co-pays are taken on a pre-tax basis and have therefore already been subject to a tax savings.

Long Term Care

Long Term Care Insurance

University Health System offers all eligible Residents (20 standard hours or more) the opportunity to purchase Long Term Care insurance through MedAmerica. This insurance can minimize the financial impact of needing care when you or your spouse cannot perform the activities of daily living such as bathing, eating, dressing, toileting, continence, and transferring due to a disabling injury, chronic medical condition or the effects of aging.

The long term care policy provides a monthly cash benefit upon eligibility. Funds may be used for:

- Nursing home care/ assisted-living facility
- Home healthcare aide
- Pay for family caregivers
- Offer your family a break from the demands of providing care
- To pay for household services or remodeling

Both employees and their spouses who are actively at work are eligible to enroll for the long term care policy which requires each individual to respond to six health questions. By purchasing this benefit through University Health System, employees and their spouses will receive discounted premiums and limited underwriting.

Optional Riders

Employee and their spouses can choose Optional Riders (add-ons to maximize benefits) at an additional cost. Optional Riders include but are not limited to the below:

Inflation Rider - Employees and their eligible spouses can choose to increase the maximum cash benefit and monthly cash benefit to protect against the anticipated increases in the cost of long term care. Options include 3% or 5% simple or compound interest.

Restoration of Benefits - Employees and their eligible spouses can choose to restore their policy's maximum cash benefit to what it would have been had no benefits been paid, if a period of 180 days elapses in which you are not chronically ill.

Shared Cash Benefits - Employees and their eligible spouses can use their spouse's benefits (with spouses' consent) should they exhaust their own maximum cash benefit.

How to Enroll

For more information, an application and/or rates, call (877) 340-7707.

Customize Your Policy	
Maximum Cash Benefit	$100,000, $200,000 or $300,000
Maximum Monthly Benefit Amount	$1,500, $3,000, $4,500, $6,000 or $7,500
Elimination Period (Waiting period before you can receive benefit payment.)	30, 60 or 90 days

Retirement Plan

457 Retirement Savings Plan

Retirement Savings Plans provide a way for residents to build their retirement savings on a pre-tax basis through payroll deduction. “Deferred Compensation” means that a certain portion of current earnings are set aside without being taxed and are invested in investment vehicles where money grows on a tax-deferred basis until the resident retires or separates from the Health System. The program allows all residents of the Health System to participate in a savings program that provides considerable savings from an income tax standpoint, as authorized by the Internal Revenue Service. Residents may begin deferring compensation into their accounts at any time and may defer as much as they wish, up to current annual limits established by law.

Vesting:

There are no vesting requirements for the 457 Retirement Savings Plan. You are always vested in your own contributions and interest.

Participation in the Health System’s Retirement Savings Plan is entirely voluntary. However, we strongly recommend that you begin saving for your retirement at the earliest possible date and give every serious consideration to the advantages the Health System’s Plans can offer.

How to Enroll:

Representatives of the authorized investment organizations are available to help you enroll in the Plan and explain the many investment vehicles available to you.

University Health System has authorized the following organizations to provide investment products to Health System residents.

ING
www.ingretirementplans.com
(210) 979-8277

VALIC
www.valic.com
(210) 275-9118

Withdrawals:

In the case of an unforeseeable emergency, a participant may apply for withdrawal of an amount reasonably necessary to satisfy the emergency need. Withdrawals for other purposes or in greater amounts would defeat the purpose of the plan and are not permitted by law. Withdrawals are not allowable to the extent that the hardship is or may be relieved:

- through reimbursement of lost compensation by an insurance company or otherwise;
- by liquidation of the employee’s asset to the extent the liquidation would not, in itself, cause severe financial hardship; or
- by cessation of deferrals under the Plan.

Retirement Plan Summary

Plan	Deduction Amount
457 Retirement Savings Plan	1-100% of gross pay, but no more than $17,000*

*Contribution Limits are reviewed and updated annually by the IRS. Please contact Human Resources for the current contribution limit released subsequent to this publication.

Additional Benefits

Cafeteria Discounts

The Identification Badge entitles each employee and volunteer to a discount on food purchased in our cafeterias on all purchases exceeding 50 cents.

Choice CARE Employee Assistance Program (EAP)

The Choice CARE Employee Assistance Program is a completely free and confidential counseling and support service for Health System employees and their families. Choice CARE counselors will provide counseling at no cost to regular full- and part-time employees, their spouse and dependent children under the age of 21 living at home. Each family member is entitled to eight sessions per problem, per year for marital, family, behavioral, substance abuse, grief, depression and other forms of counseling support.

Credit Union

Membership in the San Antonio Credit Union is available to Health System employees.

Employee Health and Wellness Services

Upon initial employment and annually thereafter, each employee receives a health and wellness screening in the Employee Health Clinic. The screening includes free immunizations, blood pressure check and a PPD (TB) skin test. Free flu shots are also available at specified times during the year. The clinic also serves as the first support if you are injured on the job.

Jury Duty

Regular full-time or regular part-time employees will receive pay at his or her regular rate of pay for each regularly scheduled work day required to serve as a juror, in addition to any pay provided by the court.

Lactation Rooms

The Health System offers two lactation rooms located within the NICU on the fifth floor of University Hospital for all employees.

The goals of the Employee Lactation Center:

- Encourage continuation of breast feeding after returning to the workplace.
- Provide the working mother at University Health System with a comfortable, safe, clean, and private environment to pump breast milk.
- Provide safe storage of the working mother's breast milk in refrigerators with limited access which are monitored for temperature.
- Lactation rooms are open 24 hours a day.

For further details, call 358-1593.

Leave of Absence and/or FMLA

A leave of absence can be granted to eligible, full-time and part-time employees under a comprehensive leave plan that allows extended periods of time off for family and medical leave, reservist and military leave, and sabbatical leave.

FMLA

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

• For incapacity due to pregnancy, prenatal medical care or child birth;

• To care for the employee's child after birth, or placement for adoption or foster care;

• To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or

• For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

• Interfere with, restrain, or deny the exercise of any right provided under FMLA;

• Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:

1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627

WWW.WAGEHOUR.DOL.GOV

NOTICES

Women's Health & Cancer Rights Act Annual Notice

Do you know that the Family Care Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy including lymphedema? If you have questions about this notice or about the coverage described herein, please contact CFHP at 358-6090.

Notice of Grandfathered Status Under the Patient Protection Affordable Care Act

As permitted by the Patient Protection and Affordable Care Act (the Affordable Care Act), a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. This group health plan believes this coverage is a "grandfathered health plan" under the Affordable Care Act.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources at 358-2275. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact the Texas Medicaid or CHIP office at 1-800-440-0493 (https://www.gethipptexas.org) or dial 1-877-KIDS NOW (www.insurekidsnow.gov) to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, University Health System will permit you and your dependents to enroll in the Family Care Plan (as long as you and your dependents are eligible, but not already enrolled in the plan). This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Notes