SUMMARY OF MATERIAL MODIFICATIONS
To the Summary Plan Description of
The Curators of the University of Missouri
Retiree Group Health Plan
Effective January 1, 2016

To: All Plan Participants of the Curators of the University of Missouri Retiree Medical Plans

This notice, called a “Summary of Material Modifications” (SMM), advises you of changes to your coverage under the PPO, Healthy Savings Plan and myRetiree Plan. Please read this notice carefully and, if you have any questions, please contact the HR Service Center.

It is important that you keep this notice with your Plan Document/Summary Plan Description (SPD) and make a note in your SPD as to what sections have been changed, since this material plus the SPD comprise your complete SPD.

In the event of any discrepancy between this SMM and the SPD, the provisions of this SMM shall govern.

Changes have been made to the Plan Document/Summary Plan Description as follows:

<table>
<thead>
<tr>
<th>Covered Medical Services (PPO and Healthy Savings Plan)</th>
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<tbody>
<tr>
<td>Include under: <strong>Bariatric Surgery</strong></td>
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<tr>
<td>The following should be noted:</td>
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<tr>
<td>Insert the following after 6) on page 22.</td>
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<tr>
<td>7) If you have had obesity surgery under the University of Missouri’s medical plan, band manipulations will be covered without an additional $2,500 copay. If your obesity surgery was performed under a non-university medical plan, the $2,500 copay will apply for the first band manipulation. Additional band manipulations will not be assessed the $2,500 copay.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Excluded Medical Services (myRetiree)</th>
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<tbody>
<tr>
<td>Include under: <strong>Bariatric Surgery</strong></td>
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<tr>
<td>The following should be noted:</td>
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<tr>
<td>Insert the following after “the participant pays a $2,500 co-payment toward…” on page 34:</td>
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<tr>
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UNIVERSITY OF MISSOURI

Medical Benefits Plan

myRetiree Health Plan and
myRetiree Health Plan – No Rx

Effective Date January 1, 2016
This Summary Plan Description (SPD) is designed to provide an overview of the University of Missouri’s myRetiree Health Plan and myRetiree Health Plan no Rx. No oral interpretations can change this Plan. While the University hopes to offer participation in this Program indefinitely, it has the right to suspend, discontinue or amend or terminate the Plan at any time for any reason. Changes in the Plan may occur in any or all parts of the Plan including Benefit Coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions, eligibility and the like. Such action may affect retired employees and may be in the form of benefits or contribution amounts. If the plan is terminated, amended or Benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination. The Plan shall be construed and administered to comply in all respects with applicable federal law. In addition to this SPD, we will continue to use other methods of communication such as memos, meetings, newsletter articles or electronic media to help you stay informed.

The program is governed by a legal document called a plan document. The University has taken care to present the information contained in this SPD in a way that is both accurate and easy to understand. However, in the event of a disagreement between this SPD and the plan document, the plan document will be followed.

It’s important for you to have a good understanding of all this Program has to offer. Please review this SPD carefully.

If you have questions, contact your Retiree Benefits Representative at the address or phone number shown below.

<table>
<thead>
<tr>
<th>Columbia, Extension, System, Health Care and Retirees</th>
<th>Total Rewards Webpage:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mailing Address:</strong> myTotal Rewards Woodrail Centre 1000 West Nifong Boulevard Building 7, Suite 210 Columbia, MO 65211</td>
<td><a href="http://www.umsystem.edu/myTotalRewards">http://www.umsystem.edu/myTotalRewards</a></td>
</tr>
<tr>
<td><strong>Office Address:</strong> Woodrail Centre 1000 West Nifong Boulevard Building 7, Suite 210 Columbia, MO 65211</td>
<td></td>
</tr>
<tr>
<td><strong>Telephone:</strong> (573) 882-9810 1-(800)-488-5288</td>
<td></td>
</tr>
<tr>
<td><strong>Fax:</strong> (573) 884-5422</td>
<td></td>
</tr>
<tr>
<td><strong>E-mail:</strong> <a href="mailto:retirement@umsystem.edu">retirement@umsystem.edu</a></td>
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</tbody>
</table>
# Table of Contents

## Table of Contents ......................................................................................................................................................... 3

## Eligibility and Enrollment .................................................................................................................................................. 5

- Retiree Eligibility .......................................................................................................................................................... 5
- Dependent Eligibility ................................................................................................................................................. 5
- Changing Your Coverage ............................................................................................................................................ 6
- Enrollment Change ....................................................................................................................................................... 6
- Qualifying Family Status Change ............................................................................................................................... 6
- Suspension Policy ......................................................................................................................................................... 6
- Annual Enrollment ...................................................................................................................................................... 7
- Re-Enrollment in the Medical Program ....................................................................................................................... 7
- Funding—Cost of Plan ............................................................................................................................................... 7

## How the MyRetiree Health Plan/MyRetiree Health Plan No RX Works ................................................................. 9

- Reasonable and Customary Charges (Out of Network Coverage) ........................................................................... 9
- Covered Medical Services ........................................................................................................................................ 9
- Two Choices for Treatment .................................................................................................................................. 9
- The Network ............................................................................................................................................................. 9
- Network Benefits .................................................................................................................................................... 10
- The Annual Deductible .......................................................................................................................................... 10
- Family Deductible Limit (3 or More Participants) ................................................................................................. 10
- Common Accident Deductible ............................................................................................................................... 10
- Copays .................................................................................................................................................................... 10
- Coinsurance ............................................................................................................................................................ 10
- Out-of-Pocket Limit ............................................................................................................................................ 10
- Maximum Program Benefit ................................................................................................................................ 10
- Utilization Management—For Dependents Not Covered by Medicare ................................................................. 11
- Precertification Before Hospitalization or Surgery (Including Outpatient Surgery) ......................................... 11
- Precertification Penalty ...................................................................................................................................... 11
- Second Surgical Opinion Benefit ......................................................................................................................... 12
- Maternity and Newborn Care ............................................................................................................................... 12
- Low Income Subsidy (LIS) .................................................................................................................................. 12
- Mental Health and Chemical Dependency Benefits ............................................................................................ 12

## Prescription Drug Benefits for MyRetiree Health Plan-Rx ......................................................................................... 13

- Short-Term Therapy Drugs – Retail Pharmacy ....................................................................................................... 13
- Long-Term Therapy Drugs – Mail Order and Maintenance Drug Program Pharmacies ........................................ 14
- Vacation Supply/Overseas Pharmacies— ........................................................................................................... 15
- Nursing Home Coverage of Prescriptions ............................................................................................................. 15
- Step Therapy .......................................................................................................................................................... 15
- Prescription Drug Out-of-Pocket Limit ................................................................................................................... 16
- Drugs Not Included for Coverage ......................................................................................................................... 16

## Other Important Information ........................................................................................................................................... 17

- Benefit Summaries .................................................................................................................................................. 17
- Coordination of Benefits ....................................................................................................................................... 17
- Coordination with Medicare .................................................................................................................................. 17
- When Coverage Ends .......................................................................................................................................... 17
- Continuation of Coverage for Dependents After the Death of Retiree ............................................................... 18
- Continuation of Medical Program Coverage (COBRA) ......................................................................................... 18
- Eligibility for Continued Coverage ....................................................................................................................... 18
- Divorced Spouse or Sponsored Adult Dependents at Least Age 55 ................................................................. 19
- Application for Continued Coverage .................................................................................................................. 19
- Cost of Continued Coverage ............................................................................................................................... 19

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Effective Date 1/1/16
BENEFITS UNDER CONTINUED COVERAGE ............................................................................................................................. 19
CONVERSION OF MEDICAL BENEFITS UPON TERMINATION .................................................................................................. 19
FILING A CLAIM FOR BENEFITS .............................................................................................................................................. 20
HOW BENEFITS WILL BE PAID ................................................................................................................................................ 20
CLAIM DISCOUNTS OR WRITE-OFFS ....................................................................................................................................... 20
CLAIM QUESTIONS ............................................................................................................................................................... 20
CONFIDENTIALITY OF INFORMATION ...................................................................................................................................... 21

BENEFIT SUMMARIES........................................................................................................................................................ 22
MYRETIREE HEALTH PROGRAM (RX AND no RX) BENEFIT SUMMARY .............................................................................. 22
MYRETIREE HEALTH PLAN-RX PRESCRIPTION DRUG BENEFIT SUMMARY ............................................................... 23

KEY TERMS ......................................................................................................................................................................... 24

ELIGIBLE EXPENSES AND EXCLUSIONS ........................................................................................................................ 27
COVERED MEDICAL EXPENSES ............................................................................................................................................ 27
COVERED MENTAL HEALTH CHARGES .................................................................................................................................. 29
COVERED CHEMICAL DEPENDENCY CHARGES ...................................................................................................................... 30

EXCLUSIONS AND LIMITATIONS........................................................................................................................................ 32
EXCLUDED MEDICAL EXPENSES ........................................................................................................................................... 32
EXCLUDED MENTAL HEALTH/CHEMICAL DEPENDENCY EXPENSES ......................................................................................... 34

CREDITABLE COVERAGE DISCLOSURE NOTICE FOR MYRETIREE HEALTH PLAN............................................................... 36
WHEN CAN YOU JOIN A MEDICARE DRUG PLAN? ................................................................................................................. 36
WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN? ...................... 36
WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?....................................................... 36
FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE… .................. 37

NON-CREDITABLE COVERAGE DISCLOSURE NOTICE FOR MYRETIREE HEALTH PLAN-NO DRUG COVERAGE 38
IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE ...................................................... 38
WHEN CAN YOU JOIN A MEDICARE DRUG PLAN? ................................................................................................................... 38
WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?....................................................... 38
WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN? ...................... 39
FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE… .................. 39

4 Effective Date 1/1/16
Eligibility and Enrollment

The University of Missouri offers Medicare eligible retirees a choice for post-employment health care. Retirees may enroll in the myRetiree Health Plan or the myRetiree Health Plan no Rx. The myRetiree Health Plan provides retirees and dependents with medical and prescription drug coverage.

The myRetiree Health Plan no Rx provides only medical coverage for retirees and dependents and does not include prescription drug coverage. Once a retiree or dependent is enrolled in myRetiree Health Plan no Rx, they can no longer change enrollment to the myRetiree Health Plan.

Retiree eligibility

You are eligible for this program if you qualify for Medicare due to age or disability. You must be enrolled in Medicare Part A and/or Part B, regardless if you are enrolled in another medical plan. In order for University retirees to be eligible for the benefits described in this Summary Plan Description (SPD), they must have been covered under a University medical program immediately prior to their retirement, be Medicare eligible, and either:

- Retire from the University of Missouri and immediately began to receive retirement benefits under the University of Missouri Retirement, Disability and Death Benefit Plan, Civil Service Retirement System, Federal Employees Retirement System or Missouri State Employees Retirement System, or
- Terminate employment with the University and be eligible at that time to begin receipt of retirement benefits under the University of Missouri Retirement, Disability and Death Benefit Plan, Civil Service Retirement System, Federal Employees Retirement System or Missouri State Employees Retirement System, but elect to defer receipt of their benefits to a later date.

If you are a retiree and enrolled as a dependent of an active employee, you may suspend your retirement coverage and remain on their insurance coverage until you become Medicare eligible due to age or disability. At that time you are no longer eligible to be covered as a dependent and must enroll in your own University retirement medical plan. It is your responsibility to contact the Retirement office prior to your Medicare eligibility. Failure to do so may result in unpaid claims.

Dependent eligibility

If dependents are covered prior to retirement, retiree may elect to continue dependent coverage. Dependent Coverage becomes effective on the date the retiree’s Coverage becomes effective, if they have completed and returned the Plan Enrollment Form with each Dependent’s name and Social Security number listed within 31 days of their Retirement.

Retirees are not eligible to add Dependents to their medical plan coverage after the date of retirement, unless the dependent is a child that experiences a qualifying family status change, then the dependent child can be added back during Annual Enrollment.

Your eligible dependents include your spouse or sponsored adult dependent and each of your natural children, stepchildren, foster children, adopted children or child placed in your home for adoption younger than age 26.

If your child is dependent on you because of a physical or mental disability they may remain covered by the plan as long as they remain incapacitated. The child must be unmarried, dependent on your or your spouse or sponsored adult dependent for principal financial support and incapable of self-sustaining employment prior to reaching the maximum age for coverage as a dependent. In this situation, you must notify the University and submit proof of the child’s status within 31 days prior to the date he or she would otherwise become ineligible.
If you are eligible for medical coverage based on your employment or your retirement with the University you may be covered under your own employment or you may be covered as a dependent unless you are Medicare eligible. You may not be covered both as a dependent and as an employee or retiree.

If you and your spouse or sponsored adult dependent work for or retired from the University and you have children, only one of you may claim the children as covered dependents.

The Plan will not cover a person who becomes your Dependent after the date of your retirement, unless the dependent is a child and experiences a qualifying status change.

Changing your coverage
You may change your coverage level during the plan year. However, you may only decrease coverage levels. You may not enroll in additional coverage after your date of retirement. You may obtain benefit change forms at https://www.umsystem.edu/totalrewards/forms-guides

Enrollment Change
To make a change, you must submit a new enrollment form to a UM Retiree Benefits Representative during the annual enrollment period. Please note that enrollment changes are only available to those who are currently enrolled.

Qualifying Family Status Change
You may decrease your Coverage level (ending Coverage or dropping Dependents) during the Plan year at any time since premiums are paid on an after-tax basis, however, you will not be able to add dependents back to the plan once they have been removed, unless the dependent is a child that experiences a qualifying family status change, then the dependent child can be added back during Annual Enrollment.

Retirees Qualifying Family Status Changes are limited to:
1. divorce, legal separation, or annulment;
2. death of Spouse or Sponsored Adult Dependent;
3. a change in the number of Dependent Children as a result of birth, adoption, death or a Child ceasing to be eligible as described above under “Dependent Eligibility”; or
4. loss of coverage by Dependent Child(ren)
5. a change in entitlement to Medicare or Medicaid for you, your Spouse, your Sponsored Adult Dependent or a Dependent Child.

Changes can only be made during the Annual Enrollment Change Period unless you have a qualified Family status change, which allows you to decrease Coverage, these changes much be made within 31 days of the event.

You and your dependents must be covered by the same medical coverage program.

Suspension Policy
Retirees are eligible to suspend medical coverage. In order to suspend coverage you must have been enrolled as a retiree for at least one month. You may elect to suspend coverage for yourself and/or your covered dependents during any period that you are covered under another non-University health care plan (other than Medicare or Medicaid) that, effective January 1, 2010, has a calendar year deductible of no greater than $1,500 and has a coinsurance requirement of no greater than 20%. Coverage may be suspended only as of the last day of any calendar month and you must notify the Retiree Benefits Representative in advance and in writing that you wish to do so.

Following the suspension of coverage, you may subsequently resume participation in this plan by requesting it during annual enrollment and coverage will resume as of the next January 1. At that time you must provide
satisfactory proof that the other coverage was in effect during the entire period of suspension and that it meets the suspension policy deductible/co-insurance requirements.

**Annual Enrollment**

During the annual enrollment period, retirees will have the option to change medical plans and/or decrease coverage level.

Retirees will receive detailed information regarding Annual Enrollment from the Total Rewards Department notifying them of plan changes for the upcoming calendar year. Benefit changes made during Annual Enrollment will be effective January 1 of the following year.

**Re-Enrollment in the Medical Program**

As a Retiree you may elect to terminate any medical insurance Program Coverage either for yourself and/or any eligible Dependents at any time, but Coverage may not be reinstated at a later date except as described under the Enrollment Suspension Policy above.

**Funding—Cost of Plan**

The premium cost of medical coverage is shared between you and the University. The University contribution amount is determined on the basis of your retirement date and the actual program under which your retirement benefit is payable.

If you retired prior to September 1, 1990 under the University of Missouri Retirement, Disability and Death Benefit Plan, Civil Service Retirement System, Federal Employees Retirement System or Missouri State Employees Retirement System, the University pays 66 2/3% of the cost of the myRetiree Health Plan. You pay the remaining cost. This percentage is applicable to coverage for the retiree only. Eligible dependents are subsidized at ½ of the retiree’s subsidy. Upon your death, the University continues to pay 1/3 of the cost of this Program so long as they remain eligible.

If you retire on or after September 1, 1990 under the University of Missouri Retirement, Disability and Death Benefit Plan, or Missouri State Employees Retirement System, the University will pay a percentage of the premium cost of your own coverage. The percentage will be computed individually for every retiree and is based on age and length of service at retirement. The University’s percentages for retirees will not exceed 73% of the cost of the Program. Fifty percent of the percentage applicable to you will be paid toward the cost of coverage for your dependents.

**Retired Employee and Dependents Contributions**

Retired Employees who retired prior to December 8, 1989 under the University of Missouri Retirement, Disability and Death Benefit Plan, or the Missouri State Employees Retirement System and Retired Employees who retired under the Civil Service Retirement System, regardless of the date of such retirement:

For such Retired Employees and Dependents enrolled in the myRHP or myRHPnRX program, the Retired Employee's contribution will be one-third (1/3) of the amount required for participation in the Program. The University will contribute the remaining two-thirds (2/3) of the required total contribution. This ratio shall apply for the Retiree as well as the covered Dependents of the Retiree provided the Retiree is living.

Surviving Spouse of an Employee who retired prior to December 8, 1989 or surviving spouse of an Employee whose date of death was prior to December 8, 1989, or Surviving Spouse of an Employee who retired under the Civil Service Retirement System, regardless of the date of such retirement:
For such Surviving Spouse and eligible Dependent(s) enrolled in the myRHP or myRHPnRX program, the Surviving Spouse shall contribute two-thirds (2/3) of the total amount required for participation in the Program. The University will contribute the remaining one-third (1/3) of the required total contribution.

Retired Employee who retires on or after December 8, 1989 under the University of Missouri Retirement, Disability and Death Benefit Plan, or the Missouri State Employees Retirement System, and Surviving Spouses and Dependents of either an Employee or Retiree as described herein whose date of death is on or after December 8, 1989.

For such Retirees and Surviving Spouses and other Dependents, the University’s monthly contribution will be calculated based on the "Percent of UM Maximum Premium Subsidy" as described in (a) below and the specific medical benefit Program in which the Retiree or Surviving Spouse is enrolled as described in (b), below.

a) The University's monthly contribution for Retired Employees will be calculated based on the following table:

<table>
<thead>
<tr>
<th>Age at Retirement Plus Years of UM Service Credit</th>
<th>Percent of UM Maximum Premium Subsidy*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 75</td>
<td>50%</td>
</tr>
<tr>
<td>Equal to or greater than 75 but less than 90</td>
<td>75%</td>
</tr>
<tr>
<td>Equal to or greater than 90</td>
<td>100%</td>
</tr>
</tbody>
</table>

*The Maximum Subsidy is a percentage of the total cost of the respective Programs, as shown below:

myRetiree Health Programs = 66\(\frac{2}{3}\)%

i) For Spouses, Surviving Spouses and other covered Dependents of Retired Employees, the University's subsidy will be one-half of the Percentage determined from the above table.

ii) For Retired Employees who retired after December 6, 1991 and on or before August 31, 1992 under the University of Missouri Retirement Plan in accord with amendments to said plan approved by the University’s Board of Curators on December 6, 1991, the Age at Retirement or Years of UM Service Credit will be adjusted to the greater value calculated by using either (but not both) of the following:
   - Age at Retirement increased to 65, or
   - Years of UM Service Credit increased by 3.

iii) For Retired Employees who retired after December 3, 1999 and on or before September 1, 2000 under the University of Missouri Retirement Plan in accord with amendments to said plan approved by the University’s Board of Curators on December 3, 1999, the Age at Retirement or Years of UM Service Credit will be adjusted to the greater value calculated by using either (but not both) of the following:
   - Age at Retirement increased to 65, or
   - Years of UM Service Credit increased by 3.

b) RHP and RHPnRx:

For Retirees, Surviving Spouses and eligible Dependents enrolled in these Programs, their contribution will be the total amount required for coverage, less an amount equal to the University’s contribution which is a portion of the total cost of the applicable Program.
equal to the Percent of UM Maximum Premium Subsidy of the applicable Program, as determined in accordance with (a), above.

How the myRetiree Health Plan/myRetiree Health Plan No Rx works

The myRetiree Health Plan/myRetiree Health Plan No Rx plans have network and non-network benefits available. The medical benefits are different for network and non-network providers. If you are Medicare eligible, Medicare is the primary payer and the University of Missouri is the secondary payer. The University of Missouri myRetiree Health Plan/myRetiree Health Plan No Rx is not a supplemental or gap plan and may be used worldwide.

Reasonable and customary charges (Out of network coverage)

Payments for your covered medical expenses are based on Medicare approved charges. The reasonable and customary charge is determined for the same or a similar service in a geographic area. Any portion of the eligible expense that is above the reasonable and customary charge will not be reimbursed by the Program. In addition, expenses above the reasonable and customary charge do not count toward your deductible or out-of-pocket limit.

Covered medical services

You can receive benefits only for charges incurred by a covered individual for the services and supplies listed as eligible expenses in the section called Eligible Expenses. These services and supplies must be prescribed or performed by a physician or other qualified medical provider for the medically necessary treatment of a non-occupational sickness or injury and provided based on generally accepted medical practice. The myRetiree Health Plan/myRetiree Health Plan no Rx program provides medical benefits worldwide.

Two choices for treatment

Each time you need medical treatment, you can choose how to receive your care. You may be treated by network providers or non-network providers; however, you will receive the highest level of benefits for services that are received from network providers. With the myRetiree Health Plan/myRetiree Health Plan no Rx), it is not necessary to select a primary care physician (PCP).

The network

The physicians and hospitals that are providers in the network have contracted with Coventry Health Care to be a part of the myRetiree Health Care Plan and have agreed to charge negotiated rates for specific services.

Coventry Health Care oversees selection and monitors the credentials of the physicians and hospitals that join the network.

Network benefits

Network benefits are provided for care you receive from any physician, hospital or other medical care facility participating in the network. The network is a national network with network providers located in a majority of locations around the country.

- To receive network level benefits, you are responsible for making certain services are provided by a network physician and facility
- You must meet an annual deductible for services not subject to a copay before the plan will cover the cost of the service.
- Benefits for non-network provider services in connection with a life-threatening emergency while traveling are covered at the network level.
- There are no claim forms to fill out for network treatment.
The annual deductible
Your deductible is the initial amount of covered medical expenses that you pay each calendar year before the Program will pay any benefits. Any Medicare deductible that has been satisfied will be applied toward meeting the myRetiree Health Plan deductible.

Family deductible limit (3 or more participants)
If the expenses applied to the deductible for all your covered family members combined reach the family deductible amount in one calendar year, no additional deductible will be required for any of your other covered family members for the remainder of that year.

Common accident deductible
If two or more covered members of your family are injured in the same accident, only one deductible is required for all medical charges related to that accident (if your deductible has not already been satisfied).

Copays
You pay a copay per confinement as shown in the Benefits Summary for hospital admissions, in addition to the annual deductible. This copay does not count toward your annual deductible or your out-of-pocket limit.

You will pay no more than one hospital copay in a 60-day period for any subsequent admission for the same diagnosis.

Coinsurance
After you satisfy the annual deductible and the hospital copay, if applicable, for network providers, the program pays 80% of eligible expenses until the out-of-pocket limit is reached. You pay the remaining 20%. For non-network providers, after you satisfy the annual deductible and the hospital copay, if applicable, the program pays 70% of eligible expenses until the out-of-pocket limit is reached. You pay the remaining 30%. This is called your coinsurance. Please see the section titled Benefit Summaries for more information.

Out-of-pocket limit
The out-of-pocket limit places a cap on the amount you will pay for eligible expenses in one calendar year. For all eligible expenses, you pay an annual deductible and either 20% in network or 30% out of network of the cost. Once your share of these expenses for one person in your family reaches the out of pocket limit, the program pays 100% of all remaining covered medical expenses for that calendar year for that covered person.

If the out-of-pocket expenses incurred by all of your covered family members combined reach the family out of pocket limit in one calendar year, the program pays 100% of any additional expenses incurred by any covered family member for the balance of that calendar year.

The following expenses do not count toward the out-of-pocket limit and are not paid at 100% after the out-of-pocket limit is satisfied:

- The hospital copay.
- Expenses that are not covered by the Program, such as charges above reasonable and customary, or penalties for failure to pre-certify hospitalization or surgery under the Utilization Management program.

The out-of-pocket limit does not include prescription drug deductibles or copays.

Maximum program benefit
There is no lifetime maximum benefit limit.
Utilization management—For dependents not covered by Medicare

Utilization Management, provided by Coventry Health Care, is a program that reviews hospital admissions and surgeries (inpatient and outpatient), both in advance and during treatment. This program reviews the utilization of health care services to help assure retirees and the medical program that you are receiving appropriate and necessary medical care and avoiding unnecessary or questionable services. You must follow the Utilization Management procedures or you must pay a penalty of $500 in addition to any copays or deductibles.

Utilization Management is managed and administered by an experienced staff of health care professionals at Coventry Health Care. These individuals will work with you, your doctor and the hospital in the management and delivery of health care services.

Precertification before hospitalization or surgery (including outpatient surgery)

RETIREES AND DEPENDENTS COVERED BY MEDICARE DO NOT NEED PRECERTIFICATION

FOR DEPENDENTS NOT COVERED BY MEDICARE:

- You or your doctor must call Utilization Management, prior to admission, to initiate the precertification process. The telephone number for Utilization Management is shown on your medical plan ID card. Basic information about you (the patient) and the condition causing the need for hospitalization or surgery must be provided. Any additional information will be obtained from your doctor.
- If hospitalization or surgery is needed for urgent or emergency care, you or your doctor must call Utilization Management within 24 hours or as soon as reasonably possible.
- The proposed treatment will then be reviewed according to widely accepted standards and criteria for medical admissions of the same type, taking into consideration all relevant facts and circumstances applicable to your specific case. You and your doctor will then be notified verbally and in writing as to whether the confinement meets the criteria. Since this process occurs prior to the admission, you and your doctor will have the opportunity to question or appeal the certification prior to admission to the hospital if there is any disagreement. It is especially important that Utilization Management be contacted seven days prior to non-emergency hospitalization or surgery so that it can review your treatment plan.

Once a hospital confinement is certified, whether it is on an emergency or non-emergency basis, a registered nurse will perform regular review of your medical progress. This will be accomplished through consultations with your doctors and nurses and, with your consent, through the review of your medical records. A signed release may be needed in some circumstances to authorize the nurse to review the medical records. This concurrent review is to help assure that you receive appropriate medical services.

- Another benefit of this concurrent review is that it allows Utilization Management to identify cases that require extended hospitalization and use of the Discharge Planning Program. Discharge planning involves the exploration of opportunities that would allow discharge from the hospital only when it is prudent. Utilization Management will coordinate discharge planning with your doctors, hospital nurses and social service organizations. This is to help see that a smooth and safe transition from the hospital to the home or other health care facility occurs if, for example, extended care or home health services are required.

Precertification penalty

If you do not obtain precertification before a hospital admission or outpatient surgery, you will pay an additional $500 of the covered charges. This penalty does not count toward your deductible, hospital copay or out-of-pocket limit.
Second surgical opinion benefit
In some circumstances, Utilization Management may require you to get a second surgical opinion. If you see the physician to whom you are referred by Utilization Management, the plan will pay 100% of the cost of the second surgical opinion. Otherwise, the program will reimburse the expenses like any other doctor’s office visit.

Maternity and newborn care
Maternity expenses for a retiree or a retiree’s spouse or sponsored adult dependent are eligible for reimbursement like expenses for an illness. All the provisions and limitations of the Program also apply to pregnancy.

Utilization Management must be contacted to initiate the certification process after the mother’s sixth month of pregnancy. Then, when the admission actually occurs, they should be notified again. Failure to follow Utilization Management procedures will result in a $500 penalty.

Elective abortions are not covered. The program does not cover pregnancy expenses of a dependent child.

Low Income Subsidy (LIS)
If a Member who is enrolled in the Medicare PDP has limited income and resources and needs extra help paying for Medicare PDP coverage, premiums, deductibles and copayments, they may qualify for the Low-Income Subsidy (LIS) provided by CMS. The refund received by ESI will reduce the required member contribution amount. If a Participant is eligible for LIS assistance, ESI will notify the Participant.

Mental health and chemical dependency benefits
The following limits apply to benefits for mental health and chemical dependency care:

- For network inpatient care, the Program pays 80% of eligible expenses after the annual deductible and copay have been satisfied, or 100% after the out-of-pocket limit is reached. For non-network outpatient care, the Program pays 70% of eligible expenses after the annual deductible, or 100% after the out-of-pocket limit is reached. However, all hospitalizations for dependents not covered by Medicare must be precertified as described in the Utilization Management section or a $500 penalty applies.
- For network outpatient care, the Program pays 80% of eligible expenses after the annual deductible, or 100% after the out-of-pocket limit is reached. For non-network outpatient care, the Program pays 70% of eligible expenses after the annual deductible, or 100% after the out-of-pocket limit is reached.
Prescription Drug Benefits for myRetiree Health Plan

The myRetiree Health Plan offers you prescription drug coverage for most drugs and medicines prescribed by a physician and dispensed by a licensed pharmacist, including syringes needed for administration of a drug, through Express Scripts, Inc. (ESI).

Prescription drug coverage will be provided through a Medicare Part D Prescription Drug Plan (PDP) which is managed per regulations established under the Medicare Modernization Act (MMA) of 2003 for Medicare eligible participants and is administered through ESI. Benefits will be administered in accordance with the MMA and implementing regulations issued by the Centers for Medicare & Medicaid Services (CMS). Benefits for non-Medicare eligible participants will be administered in the same manner as for Medicare eligible participants.

A Member in the myRetiree Health Plan will automatically be enrolled in the Medicare PDP offered by ESI when he or she:

1) Is eligible for and enrolled in Medicare Part A; or
2) Is enrolled in Medicare Part B; and
3) Lives in the PDP network service area, which includes the United States and Puerto Rico.

If a retiree or dependent is enrolled in another Medicare plan, including a different Medicare PDP, a Medigap policy, a Medicare Advantage plan (such as a Medicare HMO), or another employer group health plan without Medicare Part A and/or B, he or she may not be enrolled in the myRetiree Health Plan Medicare PDP. If the Member is enrolled in another Medicare plan, he or she must contact his or her Medicare plan issuer to inform it that he or she has enrolled in this Medicare PDP. If the member remains enrolled in another Medicare plan, they will be dis-enrolled from the University of Missouri PDP and will be enrolled in myRetiree Health Plan no Rx. The member will not be eligible to re-enroll in prescription drug coverage with the University.

A retiree or dependent may opt-out of Prescription Drug Coverage through the myRetiree Health Plan at the time they are initially eligible for the PDP. If a participant or dependent opts-out of Prescription Drug Coverage, they may not re-enroll in that coverage. In addition, if a participant opts-out of Prescription Drug Coverage, any Dependent enrolled on his or her myRetiree Health Plan will also be dis-enrolled, and may not re-enroll in that coverage.

To opt-out of the myRetiree Health Plan PDP administered through ESI, contact your Retirement Benefit Representative for the appropriate form. You may then be enrolled in myRetiree Health Plan No Rx or you may terminate medical coverage.

Because the University of Missouri Prescription Drug coverage is a Medicare Part D Plan, if you dis-enroll from the myRetiree Health Plan PDP and do not enroll in other Medicare Part D coverage, you may have to pay additional premiums when you enroll at a later date. See Creditable Coverage and Non-Creditable Coverage Disclosure Notices at the end of this SPD for more information regarding Creditable Coverage and possible penalties.

ESI provides managed prescription drug services through an extensive national network of retail pharmacies as well as a mail-order program. Non-network benefits are also available.

Short-Term Therapy Drugs – Retail Pharmacy

Short-term therapy drugs are medications commonly prescribed for illnesses like flu and strep throat, but may include the initial prescription for a new, long-term medication. You purchase these medications at a local pharmacy.

For retail prescription drugs, you pay a separate calendar-year drug deductible of $75 for you and each family member. After the drug deductible is met, your benefits are paid based on whether or not your prescription is filled at a participating network pharmacy or non-network pharmacy. The drug deductible does not count toward any other deductible.
• If your prescription is filled at a participating ESI network pharmacy, then you pay a portion of the cost as shown in the Benefit Summary after you have met your deductible. No claim form is required when you use your prescription drug identification card. ESI maintains a formulary, which is a list of commonly prescribed generic and brand-name drugs chosen for their quality and cost-effectiveness. The formulary is available from ESI or can be found on the UM Faculty and Staff Total Rewards Webpage: http://www.umsystem.edu/totalrewards/retirement/myretiree_health_plan
• If your prescription is filled somewhere other than a participating network pharmacy, then you must pay the difference between the pharmacy’s charge and the price an ESI pharmacy would charge for the same drug, in addition to the deductible and the greater of the copay or coinsurance after the deductible is satisfied. You are responsible for submitting a claim form to receive reimbursement.

Long-Term Therapy Drugs – Mail Order and Maintenance Drug Program Pharmacies
Maintenance/long-term therapy drugs are those drugs usually taken on a regular basis for chronic conditions such as high blood pressure, arthritis, heart problems, and diabetes. Maintenance/long-term therapy drugs may be purchased either at select Maintenance Drug Pharmacies or through mail-order service. However, it is more cost efficient to purchase these medications through the mail order service. See the Prescription Drug Benefit Summary in this SPD for member prescription drug costs.

Maintenance/long term drugs may be obtained through ESI mail order pharmacy or through selected retail pharmacies that participate in the Maintenance Drug Program (MDP). By ordering maintenance/long-term drugs through the mail, you may save time and money. Your cost for both mail order benefits and MDP benefits is shown in the Prescription Drug Benefit Summary.

When using ESI mail order pharmacy, for each copay, you may receive up to a 90-day supply of the drug. No deductible is required under the mail-order service program.
To receive your maintenance/long-term drugs from ESI through the mail, follow these steps:
• Complete a patient profile/order form.
• Attach the original prescription(s).
• Mail both forms, along with your payment, to ESI.

Maintenance Drug Program (MDP) pharmacies are select retail pharmacies that have contracted with ESI and Medicare to provide members with up to a 90-day supply of maintenance/long term drugs. When using an MDP pharmacy, for each copay, you may receive up to a 90-day supply of the drug. Prescriptions filled at an MDP pharmacy are subject to the annual deductible and treated as 3 (31) day fills.

For MDP pharmacy locations, refer to the listing provided in with your PDP identification card or contact ESI customer service.

Each order is reviewed, dispensed, and verified by a registered pharmacist at ESI. Throughout the filling of your order, it is checked several times to ensure that the correct quantity, daily dosage and strength of medication is sent to you.

Your order will normally be shipped within 10 working days after receipt by ESI to the address you indicate on the order form. To ensure security, the package will not indicate that drugs are inside.

If your prescription allows refills, the number of refills remaining will be indicated, and refill stickers will be provided for easy reordering. For a patient profile/order form, call ESI patient services at 1-888-772-5184 or contact your Retirement Benefits Representative.
Vacation Supply/Overseas Pharmacies-
A one-time 31 day vacation supply of prescriptions may be obtained from the local retail pharmacy before the regular refill date.

The administrative services contractor network does not include pharmacies outside the continental United States. In addition, their mail order service cannot mail prescription drugs out of the U.S. Accordingly, receipts for any medications obtained out of the U.S. may be submitted, with a claim form, directly to the administrative services contractor for reimbursement, but bear in mind that the pharmacy program is operated in accordance with U.S. laws as they relate to prescribing physicians as well as the prescription drugs themselves. Forms may be obtained at www.umsystem.edu/totalrewards/forms-guides.

To obtain medications prior to leaving the U.S. for an extended vacation out of the country:
1) The retiree must submit all of the following items to the administrative services Contractor Customer Service at least 30 days prior to the scheduled departure:
   a. An explanation of the dates/duration of extended out-of-country vacation.
   b. A prescription from the physician sufficient to cover the supply of medication being requested.
   c. A letter from the physician stating, in effect, that the physician agrees with or authorizes the dispensing of a (specified duration – not to exceed one year, if medication is a narcotic, a six month limit applies).
   d. A completed mail-order request form, or the name of the retail pharmacy the individual wishes to use.

For vacations in the US, arrangements may be made for early refills in either of two ways:
1. A pharmacy can contact ESI’s Help Desk to obtain an authorization override for an early refill.
2. The customer may also contact ESI’s Customer Service, explain when and how long they will be on vacation. The names and strengths of the drugs involved and the name and phone number of the pharmacy where they wish to purchase the medications needs to be provided to ESI.

Nursing Home Coverage of Prescriptions
If a retiree and/or eligible dependent(s) resides in a nursing home, prescription coverage can be obtained through the nursing home pharmacy. Provide the nursing home with the Express Scripts information so that the pharmacy may file claims directly with administrative services contractor. Network and non-network coverages apply. It is your responsibility to ensure the nursing home is filing claims appropriately with the administrative services contractor. If they will not file the claim, forms are available on-line or contact our office. You will need to complete the claim forms, attach copies of the receipts and submit them directly to the administrative services contractor.

Step Therapy
Step Therapy requires participants to use first-step, well established and cost effective drugs for certain prescriptions before allowing the use of a second-step drug. The program is for participants who take prescription drugs to treat an ongoing medical condition such as arthritis, asthma, or high blood pressure. The program is organized in a series of “steps” and generally starts with generic drugs as the first-step before moving on to a brand drug alternative.

This does not apply to any drug used by a member currently using a step two medication as long as there is not more than a 130 day lapse between the refill of the drug.

First-Step:
Generic drugs are usually in the first-step. You or your pharmacist can request your physician to prescribe a first-step drug. Only your doctor can approve and change your prescription to a first-step drug. Your copay or coinsurance is usually the lowest with a first-step drug.
Second Step:
Brand-name drugs are usually in the second step. If you have tried the first-step drug and it does not work and/or your physician determines that you need a brand-name drug for medical reasons, your physician may ask for an override to obtain approval for use of the second-step prescription drug. If the second-step drug is covered, you will be responsible for the associated copay or coinsurance.

Specialty Drugs
Specialty drugs are high cost drugs used for treatment of conditions such as multiple sclerosis, rheumatoid arthritis, cancer and other conditions. These drugs require a level of intervention and monitoring (beyond what is needed for a normal maintenance medication) to ensure quality outcomes.

When a Medicare eligible member requires the use of a specialty drug, they may obtain that drug through any retail pharmacy or mail order service such as Accredo.

When a non-Medicare eligible member requires the use of a specialty drug, they will be contacted by Accredo. Accredo will then work with the individuals, and their physicians as needed, to establish an efficient process for home delivery of these medications as well as ongoing monitoring of the management of the medications.

Non-Medicare eligible members may not obtain specialty drugs through a retail pharmacy, except for the first initial fill of the prescription.

To obtain additional information about the services of Accredo, call 1-866-413-4135.

Prescription Drug Out-of-Pocket Limit
The out-of-pocket limit places a cap on the amount you will pay for eligible prescription drug expenses in one calendar year. If you have satisfied your annual deductible, and your share of prescription drug copayments and coinsurance for one person in your family reaches the out-of-pocket limit, the plan pays 100% of all remaining covered prescription drug expenses for that calendar year for that covered person. The amount of your out-of-pocket limit is shown in the benefit summary.

Drugs not Included for Coverage
The following drugs and supplies are not covered:
• Non-legend drugs other than insulin.
• Therapeutic devices/appliances.
• Drugs intended for use in a physician’s office or other than at home.
• Investigational or experimental drugs including compounded medications for non-medical substitution.
• Prescriptions entitled under Workers’ Compensation and/or other municipal, state or federal programs.
• Drugs for any cosmetic purposes.
• Over-the-counter drugs and medicines.
• Drugs used in the treatment of sexual dysfunction including hypoactive sexual desire disorder and erectile dysfunction.
• Drugs used for the treatment of gender identity.
• Drugs used for the treatment of infertility or for ovulation stimulation
Other Important Information

Benefit Summaries
Please refer to the Benefit Summary section for a summary of all deductible, copayment, coinsurance, and benefit maximum information.

Coordination of benefits
Like most group health plans, your medical benefit program includes a coordination of benefits (COB) provision. If you or any of your dependents are eligible to receive benefits under more than one group plan, your benefits will be coordinated so the total amount paid by all plans will not exceed 100% of the allowable expenses incurred.

The following applies to COB for the plans:

Under COB, one plan is considered “primary” and the other “secondary”. The plan that is primary pays first and usually pays full regular benefits. The primary plan is determined as follows:

- If retired and Medicare eligible, Medicare is primary.
- If a plan covers a person as an active employee, that plan is primary and any plan that covers the person as a retired or former employee is secondary. If a plan covers a person as a dependent of an active employee, that plan is primary and a plan that covers the person as a dependent of a retired or former employee is secondary.
- If the patient is a dependent child whose parents are not divorced or separated, the plan of the parent whose birthday is earlier in the calendar year is primary.
- If the patient is a dependent child whose parents are divorced or separated, the following rules apply:
  - A plan that covers a child as a dependent of a parent who by court decree must provide health coverage is primary.
  - Where there is no such court decree, then the plan of the parent who has custody of the child is primary. (The plan of the custodial parent’s spouse is secondary and the plan of the other natural parent is third.) If a plan covers a person because of federal continuation-of-coverage laws, that plan is secondary to a plan that covers the person on any other basis.
- If none of the above rules apply, the plan that has covered the patient for the longer period of time will usually be primary.

To ensure you receive the benefits to which you are entitled under both plans, be sure to show the health care provider your Medicare card and your University of Missouri myRetiree Health Plan card. For example, when you file a claim for your spouse or sponsored adult dependent, be sure to file under his or her plan first. After you have received payment from your spouse or sponsored adult dependent’s plan, then you can submit a claim for payment to your plan. When you submit a claim to the second plan, be sure to include the Explanation of Benefits Summary from the primary plan, as well as another copy of the bill. Remember, if you coordinate your benefits correctly, you will receive payment faster and still have the advantage of coordinated coverage under both plans.

Coordination with Medicare
For those who retired prior to 9-1-90 OR who retired under the Civil Service Retirement Plan (also included in this category are widows/widowers whose deceased spouse retired prior to 9-1-90 OR who retired under the Civil Service Retirement Plan):

You are under the Coordination of Benefits (COB) Approach. Under this approach, after satisfying the deductible, the actual benefit payments made by Medicare are subtracted from the total charges, and the University Program then pays what they would have paid without Medicare, or the balance of the total claim, whichever is less.
For those who retired on or after 9-1-90 (also included in this category are widows/widowers whose deceased spouse or sponsored adult dependent retired on or after 9-1-90):

You are under the Maintenance of Benefits (MOB) Approach, which is a Medicare “carve out” approach. After satisfying the annual deductible, the University’s medical program coverage is first calculated as if there is no other insurance. Any amount payable by Medicare is subtracted from this amount. The excess, if any, is paid as the University Program benefit.

**When coverage ends**
Your medical coverage will end on the earliest of the following dates:
- When you cease making the required health plan contribution.
- When the University discontinues the Program.

**Continuation of coverage for dependents after the death of retiree**
If you die after retirement from the University, your eligible spouse or sponsored adult dependent may continue coverage after your death, subject to the payment of monthly contributions by your spouse or sponsored adult dependent, as described above, including coverage for your eligible children. It is important to note that the coverage for the surviving spouse or sponsored adult dependent of a retiree is available only to the person to whom the retiree was married or had an affirmation of adult sponsored partnership with the university on the date of your retirement and to whom you had been married to or had an affirmation of adult sponsored partnership with the university for at least one year preceding your death. The level of premiums will be somewhat different for widowed spouses or sponsored adult dependents in that the widowed or sponsored adult dependent will be responsible for a larger portion of the cost.

No continued coverage is available for children unless there is a surviving spouse or sponsored adult dependent who is also covered. Refer to the COBRA section below for information on continuation of coverage for your dependent children, upon your death, when no surviving spouse or sponsored adult dependent is covered.

Enrollment for continued coverage must be made within 31 days after the retiree’s death.

Coverage for any dependent will terminate on the earliest of the following dates:
- The date the individual no longer meets this plan’s definition of an eligible dependent.
- The date all dependent coverage is discontinued under this Program.
- The end of the period for which the required contributions have been made.

**Continuation of medical program coverage (COBRA)**
Federal law requires the Program to offer covered retirees and dependents the opportunity to continue coverage when it ends for certain specified reasons. This law is called the Consolidated Omnibus Budget Reconciliation Act of 1985 – COBRA. The following provisions outline the requirements for continued coverage in accordance with the law. These provisions apply only to the extent that the required period of continued coverage has not already been provided under other program provisions.

**Eligibility for continued coverage**
Dependents may continue their coverage under the group program for up to 36 months if their coverage ends for any of the following reasons:
- Divorce or legal separation from the retiree.
- The death of the retiree. (This applies to dependent children when there is not a surviving spouse or sponsored adult dependent who is also covered.)

The dependent child reaches the limiting age or otherwise ceases to qualify as a dependent under the Program.
These periods of continued coverage begin on the date of the event that caused loss of coverage.

In no event will more than a total of 36 months of continued coverage be provided to any individual, even if more than one of the above events occur.

Continued coverage ends automatically if any of the following occurs:

- The cost of continued coverage is not paid on or before the date it is due.
- An individual becomes covered under another group plan unless coverage under that other plan is limited due to the individual’s pre-existing condition.
- An individual becomes entitled to Medicare.
- The Program terminates for all retirees.
- The applicable maximum coverage period ends.

**Divorced spouse or sponsored adult dependents at least age 55** — Coverage can continue beyond the COBRA period if the continuation coverage under the Program expires when a divorced spouse or sponsored adult dependent is at least age 55. Coverage can continue for the spouse or sponsored adult dependent and eligible dependents until the spouse or sponsored adult dependent reaches age 65 or becomes Medicare eligible due to disability.

**Application for continued coverage**

When the Retiree Benefits Representative is notified that one of these events has happened, an election form will be sent explaining the conditions that apply to continued coverage.

However, in the event you become divorced or legally separated, or when your dependent child no longer qualifies as a covered dependent under the Program, you or your covered spouse or sponsored adult dependent or your covered child must notify the Retiree Benefits Representative within 60 days of the event. If you fail to do this, your dependent’s rights to continued coverage will be forfeited.

Continued coverage is not automatic. You must submit the complete election form within 60 days from the later of the following dates:

- The date you cease to be eligible under the group program.
- The date you receive the election form.

**Cost of continued coverage**

Any person who elects to continue coverage under the Program must pay on a monthly basis the total of that coverage plus any additional amount permitted by law. Your first payment for continued coverage must be made within 45 days of the date you sign the election form. Your payment must be sufficient to pay the applicable costs retroactive to the day following the event which caused coverage to end.

**Benefits under continued coverage**

Continued coverage will be exactly the same medical coverage you or your dependent would have been entitled to if the COBRA qualifying event had not occurred. Any future changes in the benefits or cost of coverage for the Program also will apply. The conversion privilege is available when the maximum period of continued coverage ends.

**Conversion of medical benefits upon termination**

The Program permits certain individuals whose medical coverage has terminated to convert to an individual medical policy without medical examination. However, no one who has been covered under the Program for fewer than three months may convert, and no one who is Medicare eligible may convert.
Application must be made for the individual policy within 31 days after coverage terminates. The claims administrator will arrange for the issuance of the individual policy, provided it does not result in over-insurance and does not violate any applicable laws.

Filing a claim for benefits
Always have your identification card with you when you visit your doctor or other health care provider.

For all expenses under the myRetiree Health Plan you must file a claim with Medicare, if you are Medicare eligible, then with Coventry unless the care occurred outside of the U.S., then claims should be submitted directly to Coventry.

Medical claim forms are available on the Faculty and Staff Benefits website. Your Retiree Benefits Representative also has a supply of all forms required to file medical claims. The completed claim forms should be submitted to the claims administrator at the address shown on the form. The instructions on the form should be followed carefully. To speed the processing of your claim, be sure all questions are answered fully. If you are also covered under Medicare, make sure the claim has first been filed with Medicare.

Some providers will file claims for you, so you should always ask at the time you receive services if the provider is taking care of filing the claim. If you are also covered by Medicare find out if the provider will be filing under both Medicare and the myRetiree Health Plan.

Everyone benefits when claims are filled out right the first time. You save unnecessary paperwork, and our health plan saves on administrative costs. The next time you file a claim, remember to:
• Make sure your expenses have reached your deductible.
• Avoid submitting the same claim twice.
• File your spouse or sponsored adult dependent’s claim under his or her plan first.
• Use a separate claim form for each family member.
• Provide your Social Security number.
• Submit copies of completely itemized bills showing the type of illness or injury.
• If you are also covered by Medicare, submit a copy of your Medicare Explanation of Benefits.

Claims should be submitted promptly (no later than 18 months for medical claims and 12 months for prescription drug claims, following the date the service is rendered). Return completed forms, correspondence and all bills according to the instructions provided on the forms.

How benefits will be paid
Benefits will be paid as soon as the necessary written proof to support the claim is received. All benefits are payable to you directly or directly to the provider of services if you have assigned benefits.

Claim discounts or write-offs
No participant is entitled to benefits for any claims which are reduced by the provider after benefit payments have been paid by a University Program. All discounts, or forgiven charges, must be applied before claims are submitted to the University Program for payment.

Claim questions
If any portion of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, there are several things that you can do to appeal the decision. Most of your questions can be answered quickly and efficiently by either calling or writing the claims administrator. The address and telephone number are shown on your ID card and on the claim forms.

If any part of your claim is denied, you or your beneficiary will be notified in writing. The notice will include:
• The specific reason for denial.
• The specific references to pertinent program provisions on which the denial is based.
• A description of any additional material or information necessary for you to substantiate your claim and an explanation of why such material is needed.

The claims administrator will respond to claims promptly. However, if you do not receive a response within 120 days, allowing reasonable time for mailing, you may assume your claim has been denied and proceed to the claim review stage.

Within 60 days after receiving notice that your claim has been denied, you or your authorized representative may submit a written request for review to the claims administrator.

In your request, state the reasons you believe the claim denial was improper, and submit any additional information, material or comments you consider appropriate. You may review any pertinent documents related to the claim.

The claims administrator’s decision will be in writing and will include specific references to the pertinent plan provisions on which it is based.

**Confidentiality of Information**

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan’s privacy notice, which was distributed to you upon enrollment and is available from the benefits manager. A HIPAA Authorization for Release of Health Information form can be obtained [https://uminofpoint.umsystem.edu/sites/hr/Benefits/HIPAA%20Release.pdf](https://uminofpoint.umsystem.edu/sites/hr/Benefits/HIPAA%20Release.pdf).

This Plan, and the University, will not use or further disclose information that is protected by HIPAA (“protected health information”) except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA’s privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or retiree benefit plan of the University.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA’s privacy rules. For a copy of the notice, please contact your Retiree Benefits Representative. If you have questions about the privacy of your health information or wish to file a complaint under HIPAA, please contact the Privacy Officer identified in the privacy notice.
### myRetiree Health Program (RX and no RX) Benefit Summary
(Available to Medicare Retirees)

<table>
<thead>
<tr>
<th>WHEN BENEFITS APPLY</th>
<th>Network</th>
<th>Non-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong>&lt;br&gt;(calendar year)</td>
<td>$325 per person&lt;br&gt;$800 per family</td>
<td>$1,000 per person&lt;br&gt;$3,000 per family</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limit</strong>&lt;br&gt;(includes deductibles &amp; coinsurance)</td>
<td>$2,000 per person&lt;br&gt;$4,000 per family</td>
<td>$3,000 per person&lt;br&gt;$6,000 per family</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Preventive care</strong>&lt;br&gt;(including routine physicals)</td>
<td>No charge to participant</td>
<td>30% after annual deductible</td>
</tr>
<tr>
<td><strong>Hospital Care</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>$325 copay per confinement, then 20% after annual deductible</td>
<td>30% after annual deductible</td>
</tr>
<tr>
<td><strong>Emergency Room Care</strong></td>
<td>20% after annual deductible</td>
<td>20% after annual deductible</td>
</tr>
<tr>
<td><strong>Urgent Care Center</strong></td>
<td>20% after annual deductible</td>
<td>30% after annual deductible</td>
</tr>
<tr>
<td><strong>Surgery – Outpatient</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>20% after annual deductible</td>
<td>30% after annual deductible</td>
</tr>
<tr>
<td><strong>Physician Visits</strong></td>
<td>20% after annual deductible</td>
<td>30% after annual deductible</td>
</tr>
<tr>
<td><strong>Physical, Occupational &amp; Speech Therapy</strong>&lt;br&gt;(Limit of 60 combined visits) Speech therapy requires authorization.</td>
<td>20% after annual deductible</td>
<td>30% after annual deductible</td>
</tr>
<tr>
<td><strong>Lab &amp; X-ray</strong></td>
<td>20% after annual deductible</td>
<td>30% after annual deductible</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment, Diabetic Supplies &amp; Prosthetics</strong>&lt;br&gt;(requires authorization for charges $1,000 and above)</td>
<td>20% after annual deductible</td>
<td>30% after annual deductible</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>20% after annual deductible up to a maximum benefit of $1,000 per calendar year</td>
<td>30% after annual deductible</td>
</tr>
<tr>
<td><strong>Mental Health and Chemical Dependency</strong></td>
<td>Inpatient: $325 copay per confinement, then 20% after annual deductible&lt;br&gt;Outpatient: 20% after annual deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td><strong>Cardiac Rehabilitation</strong>&lt;br&gt;(Limit of 36 Phase II visits in 12 week period)</td>
<td>20% after annual deductible</td>
<td>30% after annual deductible</td>
</tr>
<tr>
<td><strong>Pulmonary Rehabilitation</strong>&lt;br&gt;(Limit of 36 Phase II visits in 12 week period)</td>
<td>20% after annual deductible</td>
<td>30% after annual deductible</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>20% after annual deductible</td>
<td>30% after annual deductible</td>
</tr>
</tbody>
</table>

<sup>1</sup>Precertification required before hospitalization or outpatient surgery unless Medicare is primary otherwise a $500 penalty applies.
# myRetiree Health Plan-RX Prescription Drug Benefit Summary

| Retail Prescription Drugs\(^2,3,4,\) | Network pharmacy: $75 annual deductible (retail only and supply limited to 31 days)  
|                                            | greater of $7 copay or 20% after annual deductible\(^2\)  
|                                            | greater of $15 copay or 20% after annual deductible\(^2\)  
|                                            | greater of $30 copay or 50% after annual deductible\(^2\)  
| Non-network pharmacy: greater of $30 copay or 50% of network cost after $75 annual deductible\(^1\) |
| Mail Order Prescription\(^2,4,\) | Formulary Generic: greater of $15 copay or 20% per individual Rx for up to a 90-day supply\(^2\)  
|                                            | greater of $30 copay or 20% per individual Rx for up to a 90-day supply\(^2\) greater of $60 copay or 50% per individual Rx for up to a 90 day supply\(^2\)  
| Specialty Drugs | Supply limited to 31 days  
|                                            | Formulary Generic: 20% after deductible\(^2\)  
|                                            | Formulary Brand: 20% after deductible\(^2\)  
|                                            | Non-Formulary Brand: 50% after deductible\(^2\)  
| Out of Pocket Limit | $3,250 per person/$6,500 per family (combined limit to include retail, mail order, and Specialty Drugs) |

\(^1\)For non-network pharmacies, you pay the difference between the pharmacy’s charge and the amount that an Express Scripts pharmacy would charge for the same prescription, in addition to the deductible and a higher percentage of the covered charge.  
\(^2\)No benefit is payable for prescriptions that cost less than the stated copayment amount.  
\(^3\)This schedule of benefits also applies to Medicare participating Maintenance Drug Plan (MDP) retail pharmacies for up to a 90 day prescription drug supply. The applicable copay will apply to each 31 day supply  
\(^4\)Step Therapy process applies to applicable drugs.
Key Terms

Ambulatory surgical center
means a facility operated primarily for performing surgical procedures under the supervision of a staff of doctors. This facility must have a licensed anesthesiologist to administer anesthesia and remain present during surgical procedures, must provide nursing services and must maintain written agreements with a hospital or hospitals for the immediate admittance of patients who develop complications. This facility must not provide overnight accommodations and must maintain adequate medical records for each patient.

Carve Out
the employer or company computes or calculates what they would have paid for their employees’ medical treatments as the primary insurer. This includes the co-pay and deductible. Then, the company subtracts what they would have paid from the actual amount Medicare paid. The outcomes of the calculations must result in a positive number in order for the company to pay the difference. If the amount results in equal to or greater than the amount the employer or company would have paid, then nothing additional will be paid.

Coinsurance
is the portion of medical expenses that you are required to pay.

Copay
is the up-front charge that you pay for hospital admissions and hospital emergency room visits

Christian Science nurse
means a person who is listed in the Christian Science Journal and:
- Has completed nurses’ training at Christian Science Benevolent Association sanatorium.
- Is a graduate of another nurses’ training course.
- Has had three consecutive years of Christian Science nursing experience, including two years of training.

Convalescent care facility
means a legally constituted institution for the skilled nursing care of persons recovering from illness or injury with:
- Constant, 24 hour-a-day supervision by a doctor or registered nurse.
- The services of a doctor available at all times.
- Such nursing personnel as may be necessary to provide continuous 24-hour care of the patients.
- Maintenance of a daily medical record for each patient.
- Facilities for the full-time care of five or more patients.

In no event shall the term convalescent care facility include any institution, or part thereof, that is used principally as a facility for the aged.

Cosmetic surgery
means surgery done to alter the texture or configuration of the skin, or the configuration or relationship with continuous structures of any feature of the human body for primarily personal or emotional reasons.

Deductible
means the initial amount of covered medical expenses that you pay each calendar year.

Durable medical and surgical equipment
means equipment that is:
- Made to withstand prolonged use.
• Made for and mainly used in the treatment of disease or injury.
• Suited for use in the home.
• Not normally of use to persons who do not have a disease or injury.
• Not for use in altering air quality or temperature.
• Not for exercise or training.

Formulary
is a comprehensive list of preferred prescription medications. The formulary is designed to direct your physician to the most therapeutically beneficial and cost effective medications.

Health Maintenance Organization (HMO)
provides a wide range of services to participants and their dependents on a prepaid basis through network health care providers only.

Hospital
means a facility that:

• Is licensed as a hospital in the jurisdiction where it is located.
• Provides 24-hour continuous nursing service by registered nurses and continuous supervision by a staff of doctors.
• Has full diagnostic, surgical and therapeutic facilities.
• Is primarily engaged in providing diagnosis and medical treatment for injury and sickness.
• Regularly keeps patients overnight.

A residential treatment facility that meets this definition does not qualify as a hospital.

Life-threatening emergency
is an illness or injury that without immediate medical care could put your life in danger or cause serious harm to your bodily functions.

Mental health condition
means any condition requiring treatment or confinement for mental, emotional or behavioral disorders, including but not limited to neurosis, psychoneurosis, psychosis or personality disorder.

Network
Providers or health care facilities that are part of a health plan’s network of providers with which it has negotiated a discount. For the UM medical plans, these providers are listed on the Coventry website. Insured individuals pay less when using an in-network provider, because they provide services at lower cost UM members.

Out-of-network
Physicians, hospitals or other health care providers who are not in the Coventry network. Services received at an out-of-network provider will result in greater out-of-pocket expense for members.

Nurse practitioner
is a licensed practical nurse (LPN) or registered nurse (RN) who is providing medical services within that license.

Physician (or doctor)
means a legally qualified Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) Also, within the lawful scope of their various professions and subject to the specific benefit limitations of the plan, “doctor” shall also
mean persons licensed by the proper regulatory agency of the state to practice chiropractic, dentistry, optometry, podiatry, psychiatry and psychology.

**Plan year**
is the calendar year January 1 to December 31.

**Preferred Provider Organization (PPO)**
sometimes referred to as a participating provider organization or preferred provider option) is a managed care organization of medical doctors, hospitals and other health care providers who have covenanted with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients.

**Reasonable and Customary (R &C) Charge**
A term used to refer to the commonly charged or prevailing fees for health services within a geographic area. This generally applies when a contracted rate with Coventry is not available. Members may be asked to pay the difference between reasonable and customary charges and what the provider bills for non-network services.

**Urgent care**
is care that requires immediate medical attention but is not life threatening.
Eligible Expenses and Exclusions
Regardless of whether you select the myRetiree Health Plan / myRetiree Health Plan No Rx or the Healthy Savings Plan, the following expenses are covered, subject to limits otherwise stated.

Covered Medical Expenses
Except to the extent excluded under General Exclusions, Covered Medical Charges shall include the Reasonable and Customary Charges for services in a geographic area incurred by a Participant for the following services and supplies. Covered Mental Health Charges, Covered Chemical Dependency Charges or Covered Prescription Drug Charges are defined in later sections.

- Room and board furnished by a Hospital, except the part of such charges for room and board as exceeds the semi-private room accommodations. However, if no semi-private room is available, or if the attending Physician certifies that a private room is Medically Necessary and Appropriate, Covered Charges shall include room and board charges for the Hospital's lowest charges for a private room;
- Hospital services and supplies directly furnished and billed by a Hospital during a period of Hospital Confinement of the Participant;
- Other Hospital services and supplies directly furnished and billed by a Hospital whether or not the Participant is confined therein, provided such services and supplies are not included above;
- Hospital services and supplies directly furnished and billed by a Hospital if the Participant is treated surgically as an Out-patient in the Out-patient Surgery department of the Hospital; and Hospital services and supplies directly furnished and billed by a Hospital if such services and supplies were furnished in the Out-patient Emergency Accident department of the Hospital for Out-patient Emergency Accident care rendered;
- Diagnosis, Surgery, or treatment by a Physician, including anesthesia and the administration thereof;
- Any other medical care or services provided by a Physician in the office, home, or Hospital;
- Diagnostic laboratory and x-ray examinations, including professional fees;
- X-ray, radium and radioactive isotopes therapy, and other generally recognized types of therapy or procedures for the treatment of Injuries or Illnesses;
- Private duty skilled nursing services by a registered graduate nurse or, if none is available, by a licensed practical nurse who does not ordinarily reside in the Employee's or Retired Employee's home or who is not a relative of the Employee's or Retired Employee's (for this purpose, an Employee or Retired Employee's relatives are the Employee's or Retired Employee's Spouse or sponsored adult dependent and the Children, brothers, sisters and parents of the Employee or Retired Employee and of the Employee's or Retired Employee's Spouse or sponsored adult dependent). However, In-patient private duty skilled nursing services are not considered covered medical charges under UM myRetiree Health Plan.
- Preventive Care
- Colostomy, ileostomy and ureterostomy supplies and diabetic equipment and supplies for self-administration of insulin or other biological treatment prescribed by a Physician;
- Prosthetic appliances and Hospital-type equipment as follows:
  - Oxygen and the rental of equipment and administration thereof;
  - Rental of iron lung, equipment required for administration of oxygen, Hospital bed, wheelchair or other durable medical equipment, including equipment for the self-administration of insulin or other biologicals in accordance with the prescription of a Physician;
  - Braces, crutches and prostheses to replace lost physical organs or parts (but not including teeth or any repair or replacement thereof) or to aid in their functions when impaired, when necessitated by an Injury or Illness; provided, that with respect to the replacement of corrective shoes required in conjunction with a brace or other prosthetic device, only that portion of the cost of such shoes which is in excess of the cost of a pair of normal shoes of similar quality shall be a covered Medical Expense;
  - A prosthesis to replace hair lost as a result of a diagnosed Injury or Illness for which Benefits are payable under this Plan. Only one such prosthetic device will be covered during the individual's lifetime and Benefits will be limited to $100.
- Cranial Helmet
- Orthotics
- One pair of therapeutic shoes, including fitting of shoes and/or inserts, per calendar year for diabetic foot disease, peripheral neuropathy, or if medically necessary. Non-Emergency transportation by professional ambulance other than air ambulance to and from a Hospital in cases where, for medical reasons, transportation cannot be by private automobile or common carrier, provided that the distance to or from the Hospital or Physician is not more than one hundred and fifty miles; the charge for that part of any distance to or from the Hospital or Physician exceeding one hundred and fifty miles shall not be considered a covered Medical Expense;
- Emergency transportation by professional ambulance, air ambulance, railroad, or regularly scheduled airline from the place of Injury or Illness to and from the nearest Hospital qualified to furnish special treatment incident to such Injury or Illness, regardless of distance, where transportation by private automobile is medically inadvisable or impracticable;
- Room, board and general nursing care for confinement in a Convalescent Facility immediately following confinement in a Hospital for a period of at least three consecutive days under the Healthy Savings Plan, myRetiree Health Plan or myRetiree Health Plan no Rx, except that Covered Expenses will exclude:
  - Convalescent Facility daily charges incurred in excess of the Convalescent Facility's daily charge for its greatest number of two-bed rooms and
  - Convalescent Facility charges incurred after the 90th day of confinement during any one calendar year.
- Room and board and general nursing care in a free standing Hospice under a Hospice Care Plan for a Terminally Ill Participant, Emotional Support Services provided by a Hospice Care Team provided in a counseling session with the patient or the Family to assist in coping with the death of a Terminally Ill Participant and charges for home-maker services under a Hospice Care Plan;
- Phase II cardiac rehabilitation (not to exceed 36 visits in a 12 week period per incident) and pulmonary rehabilitation (not to exceed 36 visits in a 12 week period per incident) programs, provided:
  - there is documentation of an existing cardiac or pulmonary problem such as post myocardial infarction, stable angina pectoralis, post coronary artery bypass, emphysema, chronic bronchitis, bronchiectasis, post lung cancer Surgery or other cardiac or pulmonary problems of similar magnitude;
  - the Program is prescribed and followed by the attending Physician with progress reports being furnished by said Physician;
  - the Program is under the overall supervision of a Physician;
  - section reserved;
  - the Program includes appropriate monitoring and Emergency equipment administered by professionals trained in its use; and
  - in no event will any charge for membership fees or dues charged by a health club or YMCA be included as covered expenses.
- Services by a licensed dentist for the care, repair, removal, replacement or treatment of the teeth, or surrounding tissues, when necessitated by damage to teeth or surrounding tissues as a result of an Injury;
- Services by a Christian Science Practitioner who is listed as a practitioner in the Christian Science Journal current at the time such services are received if such services are elected by the Participant in lieu of the services of a Physician; provided such election is made at the time the Participant file their first claim in each calendar year; provided, however that charges made by a Physician with respect to a pregnancy shall not be subject to the terms of such election.
  - services by a Christian Science Nurse who is listed in the Christian Science Journal current at the time such services are received:
    - as having completed nurse's training at a Christian Science Benevolent Association Sanatorium, or
    - as a graduate of another nurse's training course, or
as having had three consecutive years of Christian Science nursing including two years of training provided.
• Services in connection with a voluntary sterilization procedure;
• Blood, blood plasma and blood fractions and the administration thereof except as provided at no cost (i.e., Red Cross);
• Physical, occupational and speech therapy provided by a licensed practitioner, not to exceed sixty treatments in a calendar year for the myRetiree Health Plan myRetiree Health Plan / myRetiree Health Plan No Rx, provided the Physician determines the therapy will result in a significant improvement during the course of the authorized treatment.
• For Chiropractic Care if not for maintenance purposes and if not otherwise excluded; and
• Services of a licensed birthing center.
• In connection with coverage for a medically necessary mastectomy, post-mastectomy coverage will specifically be provided as required for compliance with the Women’s Health and Cancer Rights Act of 1998 for surgery on the non-diseased breast in order to achieve the appearance of symmetry.
• Surgical treatment related to temporomandibular joint disease.
• Gastric Bypass/Bariatric Surgery as determined to be medically necessary and appropriate by the medical plan administrator. Prior authorization is required.
• Preventive immunization and screening services as identified by the Plan Administrator, which are considered “routine/preventive” for individuals with average risk factors for associated conditions. In certain situations, physicians may request that a patient with higher risk factors for specific conditions follow an accelerated screening schedule. When that occurs, the physician may submit the patient’s medical history to the plan administrator for review. Additional benefits may be payable if the medical history supports the use of additional screenings.
• Formula and low protein modified food products for children less than six years of age when recommended by a physician for the treatment of phenylketonuric or any inherited disease of amino and organic origins subject to a $5,000 per year maximum benefit.
• Genetic counseling and studies on a case by case basis that are needed for diagnosis or treatment of genetic abnormalities.
• Diabetic equipment and supplies.
• Transplants Coverage
• Those Health Services and associated expenses, authorized in advance, for transplanting an organ in accordance with the following:
  o Two phase authorization process is required as follows:
    ▪ Phase I is the initial authorization for evaluation. Authorization for evaluation does not ensure approval for the actual transplant.
    ▪ Phase II requires submission of information to determine medical appropriateness for the specific transplant.
  o Donor screening tests and services and supplies for Medically Necessary transplants are covered only if the recipient is an eligible member of the Plan.
  o Coverage includes the treatment of breast cancer by autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in autologous bone marrow transplants or stem cell transplants

**Covered Mental Health Charges**

Except to the extent excluded under General Exclusions, Covered Mental Health Charges shall include the network charges or non-network Reasonable and Customary Charges for the following Medically Necessary and Appropriate Treatment which have been incurred by a Participant as a result of a Mental Health Illness. In no event will Covered Mental Health Charges include Covered Medical Charges, Covered Chemical Dependency Charges or Covered Prescription Drug Charges.
In-patient Mental Health Treatment
Covered Charges as described in the Schedule of Benefits and subject to all other limitations described herein, include the Medical Expenses for the In-patient treatment of a Mental Health Illness if such treatment is provided in a Hospital or other Facility approved by the Plan Administrator. Covered Charges include Medical Expenses for the following:

- semi-private room accommodations;
- Medically Necessary and Appropriate services and supplies provided by the Hospital or Facility;
- charges for drugs and medicine prescribed by the attending Physician; and
- charges for In-patient Physician visits or services.

Out-patient Mental Health Treatment
Covered Charges as described in the Schedule of Benefits and subject to all other limitations described herein, include the Medical Expenses for the Out-patient diagnosis and/or Out-patient treatment of a Mental Health Illness including the following charges:

- Medically Necessary and Appropriate services and supplies provided by a Hospital or other duly licensed Facility on an Out-patient basis;
- charges for Physician's visits in-office or on an Out-patient basis at a Hospital or other Facility;
- Medically Necessary and Appropriate home health care services approved by the medical case manager.
- In no event will Covered Charges include charges incurred for treatment not under the supervision of a Physician.

Covered Chemical Dependency Charges
Except to the extent excluded under Excluded Mental Health/Chemical Dependency Charges, Covered Chemical Dependency Charges shall include the Reasonable and Customary Charges for the following Medically Necessary and Appropriate treatment which have been incurred by a Participant as a result of a Chemical Dependency Illness. In no event will Covered Chemical Dependency Charges include Covered Medical Charges, Covered Mental Health Charges, or Covered Prescription Drug Charges.

In-patient Chemical Dependency Treatment
Covered Charges as described in the Schedule of Benefits and subject to all other limitations described herein, include the Medical Expenses for the In-patient treatment of a Chemical Dependency Illness if such treatment is provided in a Hospital or other Facility approved by the Plan Administrator. Covered Charges include Medical Expenses for the following:

- semi-private room accommodations;
- Medically Necessary and Appropriate services and supplies provided by the Hospital or Facility;
- charges for drugs and medicines prescribed by the attending Physician; and
- charges for In-patient Physician visits or services.
- rehabilitative Facility care, where the Participant is admitted as a patient for a prescribed course of treatment for alcoholism or drug addiction to an Approved Rehabilitative Facility, upon the recommendation and approval of a Physician, Benefits will be payable for charges incurred for such treatment as described below:
  - Room and Board -- A Benefit equal to the Facility's charge for room and board for each day of confinement, provided however, if a private room is used, Benefits payable will not include that part of the Facility's daily charge for a private room which exceeds the Facility's daily charge for its average semi-private room.
  - Miscellaneous Fees -- A Benefit equal to the charges for services and supplies other than room and board necessary for the condition causing confinement to the extent that such charges are Reasonable and Customary as determined by the Claims Service Contractor.
  - Benefits payable shall be subject to maximum Benefits as herein otherwise provided.
Out-patient Chemical Dependency Treatment
Covered Charges as described in the Schedule of Benefits and subject to all other limitations described herein, include the Medical Expenses for the Out-patient diagnosis and/or Out-patient treatment of a Chemical Dependency Illness including the following charges:

- Medically Necessary and Appropriate services and supplies provided by a Hospital or other duly licensed Facility on an Out-patient basis; and
- charges for Physician’s visits in office or on an Out-patient basis at a Hospital or other Facility.
- In no event will Covered Charges include charges incurred for the following:
  - charges for visits in excess of the visit maximums specified in the Schedule of Benefits for Out-patient Covered Chemical Dependency Charges; or
  - treatment not under the supervision of a Physician.
Exclusions and Limitations

Regardless of whether you select the myRetiree Health Plan/myRetiree Health Plan No Rx or the Healthy Savings Plan, the following charges will not be considered covered medical expenses (subject to exceptions otherwise stated).

Excluded Medical Expenses

The Medical Expenses which are excluded from Covered Charges under this Plan are any charges:

- in connection with an Injury or Illness for which the Participant is entitled to a benefit under any Worker's Compensation Law, Occupational Disease Law, or similar act;
- as a result of an Injury or Illness resulting from war or any act of war, whether declared or undeclared, or by any act of international armed conflict, or a conflict involving armed forces of any international authority, which war or act of conflict occurs while the Participant is covered for this Benefit;
- which the Participant is not legally obligated to pay;
- for which no charges would be made if the patient had no coverage for medical care;
- for services not performed or prescribed by a Physician or not required in connection with the Medically Necessary and Appropriate treatment of accidental Injury or Illness (except for Preventive Care [myRetiree Health Plan / myRetiree Health Plan No RX only]) and as provided in the University Collected Rules and Regulations 500.010.G.1.s. and t.;
- for cosmetic Surgery, plastic surgery or treatment, unless such Surgery or treatment due to an Injury or birth defect, and which interferes with normal functions of the body or causes physical pain, or such Surgery or treatment is as described in the University of Missouri Collected Rules and Regulations Section 500.010.G.1.z;
- for dental services, except as noted in the University Collected Rules and Regulations Section 500.010.G.1.r
- for Marital or Family counseling;
- for routine eye and ear examination, the fitting of glasses and hearing aids and the cost of the appliances, except as may be required on account of the Illness or Injury to physical organs or parts or for children with developmental disabilities up to twenty-six (26) years of age;
- radial keratotomy services and treatment;
- incurred as a result of intentionally self-inflicted injuries unless such injuries are the result of a medical condition, or injuries sustained during the individual's commission of a crime;
- that are not incident to and necessary to the therapeutic treatment of accidental bodily Injury or Illness, except as provided for Preventive Care;
- for Custodial Care of Participants where medical services, if any, are only incidental;
- for special training of physically or mentally handicapped Participants where the special training furnished is primarily in the nature of educational service, rather than in the nature of medical service;
- for personal comfort items, including but not limited to television, telephones, appliances and personal comfort items and services, including, air conditioners, humidifiers, dehumidifiers, air purifiers, duct cleaning, food blenders, exercise equipment, orthopedic mattresses, whirlpools and similar items, or services, even if recommended by a Physician;
- as a result of an abortion except where the life of the mother would be endangered if the fetus were carried to term, except where medical complications have arisen from an abortion in which event those items required as a result of such medical complications shall be deemed to be covered Medical Expenses;
- genetic counseling, treatment or services unless needed for diagnosis or treatment of genetic abnormalities;
- surrogate pregnancy or the reversal of a sterilization procedure;
- treatment or services for infertility and any treatment or services related thereto, including but not limited to artificial insemination, in vitro fertilization and gamete introfallopian transfer;
- for the treatment of sexual dysfunction or gender identity;
• for the care, treatment, therapies, services, procedures, devices and supplies, which in the judgment of the Plan Administrator, are Experimental, Investigative or Unproven in nature.
• for Hospice Care Services not included in the Hospice Care Plan, or Hospice Care charges incurred prior to the date a Participant is accepted under a Hospice Care Plan;
• for Chiropractic Care in excess of $1,000, if the Participant is covered under myRetiree Health Plan / myRetiree Health Plan No Rx.
• for transportation or travel, except as provided in the University Collected Rules and Regulations Section 500.010.G.1.m. or n. ;
• that amount by which charges for medical services exceed Reasonable and Customary Charges for the services, taking into account all of the circumstances in the case;
• any reduction in claims or charges by the Health Care Provider after Benefits are paid by this Plan. All discounts or forgiven charges (charges which a Health Care Provider will not require a patient to pay) must be applied before Medical Expenses are submitted to the Claims Service Contractor.
• in accordance with the Newborn's and Mother's Health Protection Act of 1996, Covered Expenses in connection with hospital admission for childbirth will be provided hereunder for a minimum of 48 hours in the case of normal delivery and for 96 hours in connection with cesarean section.
• any treatment or services not listed in the University Collected Rules and Regulations Section 500.010.G of the University of Missouri Collected Rules and Regulations.
• the following treatment or services are excluded under the myRetiree Health Plan/myRetiree Health Plan No Rx, unless approved in advance by the Network Provider Service Contractors:
  o All Inpatient Hospital Admissions
  o All Maternity Admissions including Birthing Centers
  o Global OB
  o All Observation Admissions
  o Outpatient Surgeries Performed by a Non-participating Provider
  o All Skilled Nursing Facility, Rehabilitation Admissions
  o Hospice (inpatient and outpatient)
  o Mental Health & Substance Abuse Admissions
  o Cosmetic Services
  o Bariatric Surgery
  o Genetic Testing
  o Transplants
  o Pain Management
  o Wound Care Clinics
  o Orthotics and Prosthetics greater than $1000
  o Speech Therapy
  o Durable Medical Equipment greater than $1000
  o Home Health
  o Home Infusion Services
  o Cochlear Implants, except for a dependent child with developmental disabilities up to twenty six (26) years of age.
  o Insulin Pumps
  o CTA of the Chest
• non-surgical treatment of temporomandibular joint disease.
• Acupuncture or hypnotherapy
• bariatric surgery procedures for weight reduction unless all of the following requirements have been satisfied:
  o the individual has been a Participant under the University of Missouri Medical Benefits Plan for a period of at least three consecutive years;
  o the Participant is at least 21 years of age;
  o the Participant has a Body Mass Index equal to or greater than 35 and said index has been met for the three years prior to the date of surgery;
•  the Participant has at least one co-morbidity that is a direct complication of obesity and that has been previously unsuccessfully treated (this requirement is waived for individuals with a Body Mass Index greater than 40);
•  the Participant has, within the 24 months prior to surgery, previously completed one physician supervised weight loss attempt, for a duration no less than six months, that included behavioral therapy, diet changes, alteration of physical activity and pharmacotherapy when indicated and has been unsuccessful in this effort;
  ▪  the participant pays a $2,500 co-payment toward the cost of the bariatric surgery in addition to all other deductibles, copayments, or coinsurance that may apply under the Plan. This copayment will not apply toward the annual out of pocket limit of the Plan.

•  Developmental Delay services to include:
  o  Behavior modification - Those behavioral or educational disorder services and associated expenses related to confirmation of diagnosis, progress, staging or treatment of behavioral (conduct) problems, ADD, Oppositional Defiant Disorder, learning disabilities, developmental delays, mental retardation, anoxic birth injuries, birth defects, cerebral Injury, non-acute head injuries, or cerebral palsy;
  o  Educational Services - Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training;
  o  Treatment for disorders relating to learning, motor skills, communication, and pervasive developmental conditions such as autism, cerebral palsy and ADD;
  o  Health Services for the diagnosis and treatment of chronic brain Injury, including augmentative communication devices, developmental delay, mental retardation or cerebral palsy are not Covered;

•  Removal of benign pigmented nevi, sebaceous cysts and seborrheic keratosis (skin tags) that cause no functional impairment.

•  Enteral Feeding Food Supplement - The cost of outpatient enteral tube feedings or formula and supplies except as defined in the University Collected Rules and Regulations Section 500.010.G.1.dd of the University of Missouri Collected Rules and Regulations.

•  Duplicate durable medical equipment items, including, but not limited to, wheelchairs and oxygen tanks, unless determined to be Medically Necessary and approved by the Plan.

•  Over the counter braces, splints, and orthotics.

•  Transplant services as follows:
  o  Any transplant service deemed Experimental or Investigational
  o  Those Health Services and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not a Member unless the recipient is a Member and the donor’s medical Coverage excludes reimbursement for organ harvesting.
  o  Health Services and associated expenses for transplants involving mechanical or animal organs.
  o  Transplant services, screening tests, and any related conditions or complications related to organ donation when a Member is donating an organ or tissue to a non-Covered individual.
  o  Travel expenses

**Excluded Mental Health/Chemical Dependency Expenses**

Charges for the following Mental Health and Chemical Dependency services are excluded from Covered Charges under the myRetiree Health Plan/myRetiree Health Plan No Rx Program:

•  treatment rendered in connection with mental retardation;
•  conditions not subject to favorable modification according to generally accepted standards of psychiatric care;
•  relationship, marriage, academic and other counseling when not attributable to a mental disorder;
•  treatment for pain with physiological origins, unless the Network Provider Service Contractor determines such pain has psychological or psychosomatic components;
• psychiatric or psychological examinations, testing or treatments for purposes of school evaluations; marriage; adoptions; medical research; obtaining or maintaining employment, a license, insurance or other official document; or solely relating to judicial or administrative proceedings;
• service and treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless authorized by the Network Provider Service Contractor as Medically Necessary and Appropriate as Mental Health and Chemical Dependency services;
• experimental, investigational, controversial or unproven services, treatments, devices, or pharmacological regimens as determined by the Network Provider Service Contractor, including services utilizing methadone treatment, L.A.A.M., Cyclazocine or their equivalents;
• services for Participants who are consciously and deliberately noncompliant with Network Provider Service Contractor recommended treatment, when such noncompliance is not a direct result of a psychiatric illness;
Creditable Coverage Disclosure Notice for myRetiree Health Plan

University of Missouri CREDITABLE COVERAGE DISCLOSURE NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the University of Missouri and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. University of Missouri has determined that the prescription drug coverage myRetiree Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you are a Medicare Eligible Retiree enrolled in the myRetiree Health Plan and you join a Medicare Drug Plan, you will be moved to the myRetiree Health Plan – no Rx and your prescription drug coverage under the University of Missouri will cease. Once enrolled in the myRetiree Health Plan – no Rx, you will not be able to re-enroll in the myRetiree Health Plan with Prescription Drug Coverage. If you do decide to join a Medicare drug plan and drop your current University of Missouri coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with University of Missouri and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.
For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the University of Missouri changes. You also may request a copy of this notice at any time.

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 01/01/2016
Name of Entity/Sender: The Curators of the University of Missouri
Contact--Position/Office: Faculty and Staff Benefits
Address: 1000 W. Nifong, Bldg 7 Suite 210, Columbia, MO 65211
Phone Number: (573)882-2146

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CMS Form 10182-CC

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the University of Missouri and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The University of Missouri has determined that the prescription drug coverage offered by the myRetiree Health Plan-no RX is, on average, NOT expected to pay out as much as the standard Medicare Part D prescription drug coverage will pay and is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from University of Missouri. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with the University of Missouri, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under MyRetiree Health Plan-No Drug Coverage.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under the University of Missouri, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn’t join, if you go 63 continuous days or longer without prescription drug coverage that’s creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium.
(penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you are a Medicare Eligible Retiree enrolled in the myRetiree Health Plan-no Rx and you join a Medicare Drug Plan, your coverage will not be affected

If you do decide to join a Medicare drug plan and drop your current University of Missouri coverage, be aware that you and your dependents will not be able to get this coverage back.

**For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the University of Missouri changes. You also may request a copy of this notice at any time.

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

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**Date:** 01/01/2016

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