

General Information

The University of San Francisco offers comprehensive health benefits designed for health promotion and disease prevention. Its life insurance and disability programs are designed to help meet financial obligations associated with illness or death, while the annuity plans are designed to assist in building a retirement income.

This *Benefits Handbook* describes each of your health care, insurance, and retirement plans.

Each section begins with the information you will use most – instructions on how to file a claim, special procedures you are required to follow, phone numbers and addresses of “whom to contact,” or important information you should know about each plan.

After special instructions, you will find detailed information about plan benefits – what is covered and what is not; deductible and co-insurance amounts; and special features of your coverage.

You are encouraged to become familiar with each of your plans so that you may take maximum advantage of the benefits to which you are entitled.

NOTE: *The following material describes certain features of the University of San Francisco group benefit plans. The controlling provisions of each plan are in the master group insurance policy or agreement for that plan, and neither this description nor any certificate may in any way modify those provisions or their meaning.*

Reservation of Rights

Employer’s and Administrator’s Rights:

The Employer and the Plan Administrator retain the right to amend, delete, modify and/or terminate any of the plans referred to herein, in whole or in part, at any time, with or without notice.

The Plan Administrator has the sole and complete discretion to interpret the terms of any Plan, to resolve ambiguities and/or conflicts, and to determine and resolve claims for benefits under any Plans.

CLAIMS PROCEDURES

Each participant has a right to file a claim for benefits. The claims procedure for each benefit Plan shall be as set forth in the individual benefit Plan document. In case of any disagreement or questions as to the appropriate claims procedure, claims or request for claims information should be filed with the USF Manager of Benefits, Office of Human Resources, University of San Francisco. The Manager of Benefits will respond in writing within ten (10) working days.

Eligibility Information

WHO IS ELIGIBLE TO PARTICIPATE?

Eligibility requirements may vary for each plan. Please refer to the *Summary of Benefits Programs* to determine your eligibility for a specific plan

WHEN DOES MY COVERAGE BECOME EFFECTIVE?

If you are a new employee, your coverage will be effective as indicated in the *Summary of Benefits Programs*. If you are not actively at work on the date your coverage would normally begin, your coverage will become effective on the first day you return to active work.

In the event USF changes insurance carriers, coverage will continue with the new carrier if you are already eligible for benefits and you meet any active work requirements.

WHEN DOES DEPENDENT COVERAGE BECOME EFFECTIVE?

Dependent coverage applies only to Medical, Dental, Vision and FSAP plans. Your eligible dependents include:

- Your lawful spouse, unless legally separated or divorced.
- A Legally Domiciled Adult (LDA)* *see page 2*
- Your unmarried dependent children from birth to age 19. This includes stepchildren and legally adopted children who are financially dependent upon you and live with you in a parent-child or legal guardianship relationship. Blue Cross may require legal evidence of the decree.
- Your unmarried dependent children if they are full time students in an accredited school and qualify as dependents for federal income tax purposes. (Blue Cross – age 19 to the 25th birthday; Kaiser age 19 to the 25th birthday; Delta Dental age 19 to the 25rd birthday).
- A dependent child over 19, if a disability is cause for continued dependent status. Contact the USF Benefits Representative within 31 days after the child reaches age 19 for details about continuing insurance.
- Medical and Dental coverage for your dependent becomes effective when your coverage begins, provided you elect dependent coverage and enroll your dependents when you enroll.
- Newly acquired dependents must be enrolled within 31 days of when they become eligible. Coverage becomes effective on the date of enrollment.
- You must enroll a newborn child within 31 days after the date of birth. Coverage becomes effective at birth.
- If a dependent is confined in a hospital on the date coverage would be effective, coverage for that dependent will not be effective until the day following the dependent's final discharge from the hospital. *This does not apply to a newborn baby.*

NOTE: If you are enrolled in Blue Cross or Kaiser and do not enroll your dependents within 31 days of their becoming eligible, you cannot enroll them unless they are accepted by the health insurance plan. If your dependent is losing coverage under another Kaiser group plan, he or she may enroll in Kaiser at any time during the year. Blue Cross requires evidence of insurability (at your cost) to add dependents after 31

days of their becoming eligible. Other restrictions may apply. Refer to the Medical and Dental sections of this handbook for more detailed information.

*A Legally Domiciled Adult is someone who has lived in the same primary residence for a minimum period of time; *and*

- Intends to continue living in the same primary residence as the employee; *and*
- Shares a close personal relationship (e.g., not a casual roommate or tenant) with the employee; *and*
- Is jointly responsible with the employee for basic living expenses; *and*
- Is not married; *and*
- Is eighteen (18) years of age or older; *and*
- Is not related by blood to the employee as such that the relationship would bar marriage in the state of California; and is not receiving benefits from any other employer (however, e.g., an LDA who is receiving medical but not dental benefits from his or her employer is eligible for dental but not medical benefits from USF.);

OR

- Is an adult, dependent relative living in the same primary residence as the employee and is claimed as the employee's tax dependent (e.g., a parent, sibling or child no longer eligible for benefits.)

NOTE: If your spouse is already enrolled in USF benefits, you cannot enroll an LDA in addition to your spouse. Employees are eligible to receive benefits for either spouse or an LDA.

There are tax implications of adding an LDA to your benefits. If your LDA is not your registered Domestic Partner in California, Federal taxes, State taxes and FICA will be withheld on the value of the LDA benefits.

If your LDA is your registered Domestic Partner in California, only Federal taxes and FICA will be withheld on the value of these benefits.

This information does not constitute tax advice, please contact your tax professional, for more information.

WHAT IF MY SPOUSE OR LDA AND I ARE BOTH USF EMPLOYEES?

HEALTHCARE

If you and your spouse or LDA are both eligible employees of the University of San Francisco, both of you may be covered as employees under the medical plan, but not as a dependent of the other. If both of you are covered as employees, your dependent children may be covered by either or both of you. If you are eligible for the health plan waiver credit, you may choose to have yourself and your children covered as dependents of your spouse or LDA rather than having separate coverage. You will then receive additional income (health plan waiver credit) in your paycheck each month.

DENTAL CARE

If you and your spouse or LDA are both eligible employees of the University, you may only be enrolled under one application. Dependent children may only be covered under one plan. If the subscriber terminates or becomes ineligible, the coverage may be continued by changing the subscriber name to that of the spouse or LDA who remains in eligible employment. If a covered dependent child becomes an eligible employee of USF, his or her dependent coverage will terminate on the date he or she becomes eligible for coverage as an employee.

WHEN MAY I CHANGE MEDICAL PLANS?

At the time of initial enrollment, you are required to choose one of the two available Medical plans: USF Blue Cross Medical Plan, Kaiser HMO; or you may waive both plans by applying for the health care waiver credit. If you wish to transfer from one option to another, you may do so only during the open enrollment period. Please contact the Benefits Representative for this year's date. To transfer between Medical plans you do not have to provide evidence of insurability but you must be actively at work in order for coverage to begin. Your enrolled dependents do not have to provide evidence of insurability.

WHAT IF I BECOME ELIGIBLE FOR MEDICARE?

If you continue to work full-time beyond age 65 your primary health coverage remains with USF. Health care benefits under this plan will continue for you and your covered eligible dependents. A covered dependent spouse or LDA age 65 or over may also have this plan as his or her primary health coverage even if you are under age 65. Approximately three months prior to your 65th birthday you should apply for Medicare benefits at your local Social Security office. As long as you continue to work, USF's health plan remains the primary payer and Medicare is the secondary payer. If you or a dependent qualifies for Medicare coverage due to a disability (after January 1, 1987), you or your dependent may continue this plan for your primary health coverage. If you or a covered dependent elect in writing to have benefits paid under Medicare as your primary health coverage, then you and your dependent will no longer be covered for health benefits under this plan.

If you or a covered dependent are eligible for Medicare Benefits and USF's plan is your primary payer of medical benefits, you should submit your claims to USF's plan for payment first. After this plan makes its payment, you should then send Medicare a copy of this claim and a copy of this plan's Explanation of Benefits so that any balance may be considered for payment under Medicare. It will be your responsibility to follow-up with Medicare for their payment. You should advise all your physicians that this plan will be the primary payer, and that this plan should be billed **before** billing Medicare.

WHAT IF I HAVE OTHER COVERAGE?

Coordination of Benefits Provision

Family members are often covered under more than one health plan. This is why all USF's Medical and Dental benefit plans have a Coordination of Benefits provision. This

provision will enable you to be reimbursed for as much of your medical expenses as possible, up to 100% of allowable expenses. The combined payment cannot be more than the highest amount the plan would normally pay. If neither of the plans would consider the expense a customary and reasonable charge, then it is not a covered expense. "Covered expense," means any customary and reasonable expense for health services, treatment or supplies. If the other plan has no guidelines for coordinating benefits, the other plan will pay benefits before the USF plan.

Other group health care plans include:

- Insurance or other health care benefits for individuals of a group.
- Any self-insured employee or employer welfare benefit plan.
- Coverage where the employer makes contributions or payroll deductions.
- A labor management trustee plan, employer organization plan or employee organization plan.
- Any group, blanket or franchise disability policy.
- Any governmental program or coverage required to be provided by statute.
- Coverage for students sponsored by, or provided through, a school or other educational institution.
- Medicare benefits for the disabled or those receiving kidney dialysis.
- Benefits provided under any other health care service plan contract or any hospital service plan contract.

WHICH PLAN PAYS?

Common guidelines are used to determine which plan pays first. The plan covering the patient as an employee will be the primary plan. If both parents have group health care plans, a dependent's primary plan is determined by the parents' birthdays. The plan of the parent whose birthday comes first in the calendar year is the primary plan. For instance, if the father was born on May 15 and the mother on July 20, the father's plan would be primary. If the parents have the same birthday, the plan that has covered a parent for the longer period of time will be the primary plan.

In the case of divorce or separation, the child's coverage under the plans of the parents is in this order:

- Parent with custody
- Stepparent (if any)
- Parent without custody

If none of these situations fits, the plan covering the person the longer time pays first. If one plan covers a person as an employee and the other plan covers them as a laid-off employee or retiree, the plan covering the active employee pays first.

Right to Receive and Release Necessary Information

In coordinating benefits, the claims processors may request claim information from you, and release information to the other plan as needed without notifying you.

Facility of Payment

If payments which should have been made under this plan are made by any other group health plan or group insurer, this plan will reimburse the other health plan or insurer. Any amounts paid in that manner are considered benefits provided by this plan.

WHEN DO BENEFITS END?

The date of benefit termination varies depending on the type of coverage. Refer to the *Summary of Benefits Programs* to determine your termination date for a specific coverage.

All Medical Plans

Medical coverage for you and your dependents will automatically end on the earliest of the following dates:

- the last day of the month following the date your employment terminates (unless you have purchased COBRA coverage);
- the last day for which any contribution has been paid;
- the date this plan terminates;
- the date a dependent ceases to be eligible as defined earlier in this section;
- the date a dependent becomes eligible for coverage as an employee.

Delta Dental Plan

Delta Dental may cancel the dental program only on an anniversary date (at the end of each renewal period thereafter), or:

- if USF does not make payment to Delta as required by the contract;
- if fewer than 10 people are reported eligible for three months or more;
- if USF does not give Delta a list of who is eligible; or
- if USF does not allow Delta to inspect its records if this is required by the group contract.

If this program is canceled, you and your dependents have no right to renewal or reinstatement of your benefits.

CONTINUATION OF GROUP COVERAGE (COBRA)

COBRA, the *Consolidated Omnibus Budget Reconciliation Act* (effective January 1, 1987), requires employers sponsoring group health plans to give certain categories of employees and beneficiaries an opportunity to elect continued benefits coverage after an event that might otherwise result in loss of coverage.

COBRA regulations apply to the following plans:

- USF Self-Funded Plan (Blue Cross)
- Kaiser Foundation HMO
- Delta Dental Plan
- Faculty and Staff Assistance Program
- Flexible Spending Accounts

WHO MAY CONTINUE COVERAGE, WHEN, AND FOR HOW LONG?

If your employment terminates for any reason other than gross misconduct, or if your work hours are reduced so that your health care terminates, you and your covered dependents may continue coverage under the USF medical and dental plans for up to 18 months. If you are totally disabled for Social Security purposes, this 18-month period may be extended to 29 months. If you become eligible for a new health plan, you and your covered dependents may continue COBRA coverage if you would be denied coverage for certain conditions by the new plan's pre-existing conditions limitations.

If you should die, become divorced or legally separated, your covered dependents that are not covered under any other group health care plan may continue health care coverage under the USF plan for up to 36 months. If you become eligible for Medicare, your covered dependents will be eligible for an additional 36 months of coverage from that date. Also, your covered children who are not covered under any other group health care plan may continue health care coverage under the USF plan for up to 36 months after they no longer qualify as covered dependents under the terms of the plan.

Recently, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was enacted. It requires that employers/insurers provide former employees with proof of previous health care coverage. This is in effort to improve portability of health care for individuals by restricting an employer's or insurer's ability to use preexisting condition exclusions or limitations. USF or its insurers provide certificates that prove you had health care coverage while employed at USF. Contact the USF Benefits Representative for a HIPAA Certificate.

WHAT IS THE COST OF CONTINUED COVERAGE?

If you elect to continue coverage under the plan you must pay the full cost of coverage (including both the share you now pay and the share USF now pays), plus any additional amount permitted by law. The plan may not require any premium payment until 45 days after you elect continuation of coverage. For current COBRA rates please call the Benefits Representative.

WHEN DOES COBRA COVERAGE END?

Except in the circumstances described above, continued coverage will end for any person when:

- the cost of continued coverage is not paid on or before the 30th day after the date it is due; or
- that person becomes eligible for Medicare; or
- that person becomes covered under another health care plan, unless coverage for certain conditions would be denied by the new plan's pre-existing conditions limitations; or
- the plan terminates for all employees.

Notice of Eligibility

The USF Benefits Representative will give you and your covered dependents notice when you become entitled to COBRA coverage. However, **you or your covered spouse or LDA or dependents must first notify the Benefits Representative within 60 days after you become divorced or legally separated, or when your dependent**

child no longer qualifies as a covered dependent under the plan. After notice has been provided by the USF Benefits Representative, you and/or your covered dependents will have 60 days to elect continued coverage.

You may also be entitled to extend your COBRA Coverage period to a total of 36 months from the date federal COBRA began pursuant to a California law called Cal-COBRA if you were initially only entitled to 18 or 29 months of COBRA Coverage and you exhaust your federal COBRA Coverage. Whether or not you are eligible for this extension may depend on the type of coverage that you have at the time your COBRA Coverage is exhausted. Contact your insurance carrier or the USF Benefits Representative for more details.

CONVERSION TO INDIVIDUAL POLICY

Individual coverage may include a more limited healthcare plan, but it requires no evidence of insurability if your coverage has not lapsed prior to conversion.

Blue Cross

To convert to an individual Blue Cross policy:

1. You must have been insured for at least three months.
2. You must apply in writing to Blue Cross.
3. You must pay the first premium within 31 days after the day your insurance ended.

The converted coverage will be the plan that is offered by Blue Cross at the time you apply. You do not have to give evidence of good health. The converted coverage will cover you and your dependents that were insured under the group policy on the date your insurance ended.

Your spouse or LDA or any one of your dependent children will have conversion rights if you die while insured or if you die within 31 days after your insurance ends. Your spouse or your LDA will also have these rights if his or her insurance ends when your marriage ends. A child may exercise this right on his or her behalf, on ceasing to be a qualified family member under this plan. If your child's insurance – or the class of which your child is a member – ends, he or she will have conversion rights if not provided above.

Blue Cross conversion coverage benefits will be at least equal to the minimum requirements for coverage under the laws of the state of California. The converted coverage does not have to provide benefits that are in excess of those provided under the State of California laws.

The converted coverage may:

- exclude any pre-existing condition which was excluded in the group policy;
- reduce benefits during the first year so that you will not receive benefits under the converted coverage that would exceed benefits under the group policy;
- reduce the benefits of the converted coverage by the benefits payable under the group policy after insurance ends;
- provide for a reduction or an end to coverage when the insured person becomes eligible for coverage under Medicare or any other State or Federal program.

Kaiser Health Plan

If you are no longer eligible for group coverage, but are entitled to convert to individual coverage, you may apply without a medical evaluation for conversion to an individual Kaiser plan within 31 days after loss of eligibility. Individual Plan membership begins at the time group or COBRA coverage ends.

If you do not convert to Individual Plan coverage, all coverage ceases at the end of the last month in which you were eligible for group coverage, and for which the monthly premium has been received.

Life and Accidental Death and Dismemberment

You may apply directly to the company to continue all or part of your life insurance coverage on an individual basis. Application must be made within 31 days of your loss of eligibility for group coverage. Contact the Benefits Representative for the necessary conversion forms.

Delta Dental and Faculty and Staff Assistance Program

Conversion policies are not available for the **Delta Dental Plan** or the **Faculty and Staff Assistance Program**.