RESIDENTS AND FELLOWS

Welcome to the 2013–2014

RESIDENTS AND FELLOWS HEALTH PLAN

Administered by the Office of Student Health Benefits

Student Health Benefits

University of Minnesota
Driven to Discover℠

Basic Option

- Great choice of doctors
- Award-winning service
- Tools to stay healthy

HealthPartners®

TABLE OF CONTENTS

Summary of Benefits (SB) Effective Date: The later of July 1, 2013 and the Covered Person's effective date of coverage under the Plan.

HealthPartners Open Access Choice
Schedule of Benefits

See Sections III. and IV. of this Summary of Benefits for additional information about covered services and limitations.

The amount that the Plan pays for covered services is listed below. The Covered Person is responsible for the specified dollar amount and/or percentage of charges that the Plan does not pay.

Coverage may vary according to your network or provider selection.

These definitions apply to the Schedule of Benefits. They also apply to the Summary of Benefits.

Charge:

For covered services delivered by participating network providers, this is the provider's discounted charge for a given medical/surgical service, procedure or item.

For covered services delivered by out-of-network providers, this is the provider's charge for a given medical/surgical service, procedure or item, according to the usual and customary charge allowed amount.

The usual and customary charge is the maximum amount allowed which the Plan considers in the calculation of payment of charges incurred for certain covered services. It is consistent with the charge of other providers of a given service or item in the same region. You must pay for any charges above the usual and customary charge, and they do not apply to the out-of-pocket limit.

A charge is incurred for covered ambulatory medical and surgical services on the date the service or item is provided. A charge is incurred for covered inpatient services on the date of admission to a hospital. To be covered, a charge must be incurred on or after the Covered Person's effective date and on or before the termination date.

Combined Day Limit:

Your total benefit is combined for inpatient hospitalization, skilled nursing facility care services and inpatient behavioral health services, and limited to 365 days per period of confinement. Each day of such services provided under the Network Benefits and Out-of-Network Benefits counts toward this combined day limit, for the same period of confinement.

Copayment/Coinsurance:

The specified dollar amount, or percentage, of charges incurred for covered services, which the Plan does not pay, but which a Covered Person must pay, each time a Covered Person receives certain medical services, procedures or items. The Plan's payment for those covered services or items begins after the copayment or coinsurance is satisfied. Covered services or items requiring a copayment or coinsurance are specified in this SB.

For services provided by a network provider:
The amount which is listed as a percentage of charges or coinsurance is based on the network providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements. However, if a network providers' discounted charge for a service or item is less than the flat dollar copayment, you will pay the network providers' discounted charge. A copayment or coinsurance is due at the time a service is provided, or when billed by the provider.

For services provided by an out-of-network provider:
Any copayment or coinsurance is applied to the lesser of the providers' charge or the usual and customary charge for a service.

The copayment or coinsurance applicable for a scheduled visit with a network provider will be collected for each visit, late cancellation and failed appointment.

Deductible: The specified dollar amount of charges incurred for covered services, which the Plan does not pay, but a Covered Person or a covered family has to pay first in a plan year. The Plan's payment for those services or items begins after the deductible is satisfied. If you have a family deductible, each individual family member may only contribute up to the individual deductible amount toward the family deductible. An individual's copayments and coinsurance do not apply toward the family deductible. For network providers, the amount of charges that apply to the deductible are based on the network providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule for case rate or withhold arrangements. For out-of-network providers, the amount of charges that apply to the deductible are the lesser of the providers' charges or the usual and customary charge for a service.

Lifetime Maximum Benefit: The specified coverage limit paid for all Out-of-Network charges and actually paid for a Covered Person. Payment for Out-of-Network Benefits under the Plan ceases for that Covered Person when that limit is reached. The Covered Person has to pay for subsequent charges for Out-of-Network Benefits.

Out-of-Pocket Expenses: You pay the specified copayments/coinsurance and deductibles applicable for particular services, subject to the out-of-pocket limit described below. These amounts are in addition to your contributions.

Out-of-Pocket Limit: You pay the copayments/coinsurance and deductibles for covered services, to the individual or family out-of-pocket limit. Thereafter, 100% of charges incurred are covered under the Plan for all other covered services for the rest of the plan year. You pay amounts greater than the out-of-pocket limit if any benefit maximums are exceeded or if the lifetime maximum is exceeded.

Out-of-Network Benefits above the usual and customary charge (see definition of charge above) do not apply to the out-of-pocket limit.

You are responsible to keep track of the out-of-pocket expenses. Contact HealthPartners Member Services department for assistance in determining the amount paid by the Covered Person for specific eligible services received. Claims for reimbursement under the out-of-pocket limit provisions are subject to the same time limits and provisions described under the "Claims Procedures" section of the SB.

	Network Benefits	Out-of-Network Benefits
Individual Plan Year Deductible	$400 per person.	$400 per person.
Family Plan Year Deductible	$1,200 per family.	$1,200 per family.
	The deductibles under the Network Benefits and the Out-of-Network Benefits are combined.	
Individual Plan Year Out-of-Pocket Limit for Prescription Drugs	$750 per person.	$750 per person.
Family Plan Year Out-of-Pocket Limit for Prescription Drugs	$1,000 per family.	$1,000 per family.
	The Out-of-Pocket Limit for prescription drugs does not include prescription drugs administered during treatment in a hospital, drugs for the treatment of growth deficiency, drugs for the treatment of infertility, special dietary treatment for Phenylketonuria (PKU), injections administered in a doctor's office, durable medical equipment, diabetic supplies and amino acid based elemental formula. These listed services will apply toward the out of pocket limits for all other services, shown below.	
Individual Plan Year Out-of-Pocket Limit for all other services	$2,000 per person.	$2,000 per person.
Family Plan Year Out-of-Pocket Limit for all other services	$4,000 per family.	$4,000 per family.
	The out-of-pocket limits under the Network Benefits and the Out-of-Network Benefits are combined.	
	Out-of-Network Benefits above the usual and customary charge (see definition of charge above) do not apply to the out-of-pocket limit.	
Infertility Services Lifetime Maximum Benefit (including drugs for the treatment of infertility)	$10,000	$10,000
	The Infertility Services Lifetime Maximum Benefit is combined for the Network Benefits and the Out-of-Network Benefits.	
	Any benefits applied to the Infertility Services Lifetime Maximum Benefit shown above will also apply towards the Lifetime Maximum Benefit described below.	
Lifetime Maximum Benefit	Unlimited	Unlimited

COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

	Network Benefits	Out-of-Network Benefits
YOU ARE REQUIRED TO GET PRE-CERTIFICATION BEFORE USING CERTAIN OUT-OF-NETWORK SERVICES. SEE I.F. "CARECHECK® " IN THIS SB FOR SPECIFIC INFORMATION ABOUT PRE-CERTIFICATION.		
A. ACUPUNCTURE	80% of the charges incurred. Deductible must first be satisfied.	No coverage.
B. AMBULANCE AND MEDICAL TRANSPORTATION	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
C. BEHAVIORAL HEALTH SERVICES		
Mental Health Services		
a. Outpatient Services, including group therapy, day treatment and intensive outpatient services	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
b. Inpatient Services, including psychiatric treatment for emotionally handicapped children	80% of the charges incurred. Deductible must first be satisfied. *Limited to 365 day maximum per period of confinement, subject to the combined day limit.*	80% of the charges incurred. Deductible must first be satisfied. *Limited to 365 day maximum per period of confinement, subject to the combined day limit.*
Chemical Health Services		
a. Outpatient Services, including group therapy, day treatment and intensive outpatient services	80% of the charges incurred. Deductible must first be satisfied. *The Plan covers supervised lodging at a contracted organization for Covered Persons actively involved in an affiliated licensed chemical dependency day treatment or intensive outpatient program for treatment of alcohol or drug abuse.*	80% of the charges incurred. Deductible must first be satisfied.
b. Inpatient Services	80% of the charges incurred. Deductible must first be satisfied. *Limited to 365 day maximum per period of confinement, subject to the combined day limit.*	80% of the charges incurred. Deductible must first be satisfied. *Limited to 365 day maximum per period of confinement, subject to the combined day limit.*

COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

	Network Benefits	Out-of-Network Benefits
D. CHIROPRACTIC SERVICES	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied. *Chiropractic services are limited to a plan year benefit of $500 per person.*
E. DENTAL SERVICES **(See subsection E. Dental Services under Section III. Description of Covered Services)**		
Accidental Dental Services	80% of the charges incurred. Deductible must first be satisfied. *For all accidental dental services, treatment and/or restoration must be initiated within 12 months of the date of the injury. Coverage is limited to the initial course of treatment and/or initial restoration. Services must be provided within 24 months of the date of injury to be covered.*	80% of the charges incurred. Deductible must first be satisfied.
Medical Referral Dental Services		
a. Medically Necessary Outpatient Dental Services	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
b. Medically Necessary Hospitalization and Anesthesia for Dental Care	80% of the charges incurred. Deductible must first be satisfied. *Limited to 365 day maximum per period of confinement, subject to the combined day limit.*	80% of the charges incurred. Deductible must first be satisfied. *Limited to 365 day maximum per period of confinement, subject to the combined day limit.*
c. Medical Complications of Dental Care	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
Orthognathic Surgery Benefit	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
Treatment of Cleft Lip and Cleft Palate of a Dependent Child	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD)	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.

COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

	Network Benefits	Out-of-Network Benefits
F. DIAGNOSTIC IMAGING SERVICES *The Plan covers services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)*		
Associated with covered preventive services (MRI/CT procedures are not considered preventive)	100% of the charges incurred. Deductible does not apply.	Diagnostic imaging for preventive services is covered at the benefit level shown in the Preventive Services section.
For illness or injury		
a. Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT)	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
b. All other outpatient diagnostic imaging services	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
G. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
Special dietary treatment for Phenylketonuria (PKU)	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
Oral amino acid based elemental formula if it meets HealthPartners medical coverage criteria	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
	Wigs for hair loss resulting from alopecia areata are subject to $350 maximum benefit per plan year for Network Benefits and Out-of-Network Benefits combined. No more than a three-month supply of diabetic supplies will be covered and dispensed at a time. Diabetic supplies purchased at a network pharmacy are not subject to the deductible.	
H. EMERGENCY AND URGENT CARE SERVICES		
Convenience clinics	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
Urgent care provided at clinics	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
Emergency care in a hospital emergency room, including professional services of a physician	80% of the charges incurred. Deductible must first be satisfied.	See Network Benefits.

COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

	Network Benefits	Out-of-Network Benefits
Inpatient emergency care in a hospital	80% of the charges incurred. Deductible must first be satisfied. *Limited to 365 day maximum per period of confinement, subject to the combined day limit.* *Out-of-Network professional fees will be paid at the Network Inpatient Hospital Services Benefit level if the Covered Person is admitted inpatient to a network hospital through the emergency room.*	See Network Benefits.
I. HEALTH EDUCATION	100% of the charges incurred. Deductible does not apply.	Health education for preventive services is covered at the benefit level shown in the Preventive Services section.
J. HOME HEALTH SERVICES		
Physical therapy, occupational therapy, speech therapy, respiratory therapy, home health aide services and palliative care	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
TPN/IV therapy, skilled nursing services, non-routine prenatal/postnatal services, and phototherapy	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
Routine prenatal/postnatal services and child health supervision services.	100% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible must first be satisfied.
	If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of eight visits per plan year.	If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of eight visits per plan year.
	For all other services that meet the home health services requirements described in this SB, there is a maximum of 120 visits per plan year.	For all other services that meet the home health services requirements described in this SB, there is a maximum of 60 visits per plan year.
	Each visit provided under the Network Benefits and Out-of-Network Benefits, combined, counts toward the maximums shown above.	

COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

	Network Benefits	Out-of-Network Benefits
K. HOME HOSPICE SERVICES	80% of the charges incurred. Deductible must first be satisfied. *Respite care is limited to five days per episode, and respite care and continuous care combined are limited to 30 days.*	No coverage.
L. HOSPITAL AND SKILLED NURSING FACILITY SERVICES		
Medical or Surgical Hospital Services		
a. Inpatient Hospital Services	80% of the charges incurred. Deductible must first be satisfied. *Limited to 365 day maximum per period of confinement, subject to the combined day limit.*	80% of the charges incurred. Deductible must first be satisfied. *Limited to 365 day maximum per period of confinement, subject to the combined day limit.*
	Each Covered Person's admission or confinement, including that of a newborn child, is separate and distinct from the admission or confinement of any other Covered Person.	
b. Outpatient Hospital, Ambulatory Care or Surgical Facility Services *(to see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see the benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy)*	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
Skilled Nursing Facility Care	80% of the charges incurred. Deductible must first be satisfied. *Limited to 120 day maximum per period of confinement, subject to the combined day limit.*	80% of the charges incurred. Deductible must first be satisfied. *Limited to 120 day maximum per period of confinement, subject to the combined day limit.*
	Each day of services provided under the Network Benefits and Out-of-Network Benefits, combined, counts toward the maximums shown above.	
M. INFERTILITY SERVICES	80% of the charges incurred. Deductible must first be satisfied. *Infertility services for Network Benefits and Out-of-Network Benefits are limited to a combined $10,000 lifetime maximum benefit. Drugs for the treatment of infertility are subject to this maximum.*	80% of the charges incurred. Deductible must first be satisfied.

COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

	Network Benefits	Out-of-Network Benefits
N. LABORATORY SERVICES *The Plan covers services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)*		
Associated with covered preventive services	100% of the charges incurred. Deductible does not apply.	Laboratory for preventive services is covered at the benefit level shown in the Preventive Services section.
For illness or injury	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
O. MASTECTOMY RECONSTRUCTION BENEFIT	Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Out-of-Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.
P. OFFICE VISITS FOR ILLNESS OR INJURY		
Office Visits	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
Injections administered in a physician's office		
Allergy injections	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
All other injections	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
Convenience clinics (Includes access to Online Care through virtuwell at www.virtuwell.com)	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.

COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

	Network Benefits	Out-of-Network Benefits
Q. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY *The Plan covers services provided in a clinic. The Plan also covers physical therapy provided in an outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)*		
Rehabilitative and Habilitative therapy	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied. *Physical, Occupational and Speech Therapy combined are limited to a plan year benefit of $500 per person.*
R. PRESCRIPTION DRUG SERVICES	**Drugs and medications must be obtained at a network pharmacy**	
Outpatient Drugs	$15 copayment and 100% thereafter per prescription for generic formulary drugs. $30 copayment and 100% thereafter per prescription for brand formulary drugs. $45 copayment and 100% thereafter per prescription for non-formulary drugs. Deductible does not apply. Formulary contraceptives are covered at 100% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible must first be satisfied.
	Drugs for the treatment of sexual dysfunction are limited to six doses per month. *Specialty drugs are limited to drugs on the specialty drug list, and must be obtained from a designated vendor. For the Specialty drug benefit, see Specialty drugs which are self-administered below.*	*Drugs for the treatment of sexual dysfunction are limited to six doses per month.*

COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

	Network Benefits	Out-of-Network Benefits
Tobacco cessation products, as determined by HealthPartners. Must be prescribed by a licensed provider.	$15 copayment and 100% thereafter per prescription for generic formulary drugs. $30 copayment and 100% thereafter per prescription for brand formulary drugs. $45 copayment and 100% thereafter per prescription for non-formulary drugs. Deductible does not apply.	80% of the charges incurred. Deductible must first be satisfied.
Mail Order Drugs	You may also get outpatient prescription drugs which can be self-administered through HealthPartners mail order service. Drugs ordered through this service are covered at the benefit percent shown in Outpatient Drugs above, subject to two copayments for each 90-day supply or portion thereof. Drugs for the treatment of sexual dysfunction are limited to 18 doses per 90-day supply. New prescriptions to treat chronic conditions and trial drugs will be limited to quantity limits described at the end of this section. You will have to pay one copayment for your initial 31-day supply. Specialty drugs are not available through the mail order service. For information on how to obtain drugs through the HealthPartners mail order service, refer to your enrollment material.	See Network Benefits.

COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

	Network Benefits	Out-of-Network Benefits
Diabetic Supplies purchased at a pharmacy	$15 copayment and 100% thereafter per prescription for generic formulary drugs. $30 copayment and 100% thereafter per prescription for brand formulary drugs. $45 copayment and 100% thereafter per prescription for non-formulary drugs. Deductible does not apply.	80% of the charges incurred. Deductible must first be satisfied.
Drugs for treatment of infertility	$15 copayment and 100% thereafter per prescription for generic formulary drugs. $30 copayment and 100% thereafter per prescription for brand formulary drugs. $45 copayment and 100% thereafter per prescription for non-formulary drugs. Deductible does not apply. *Infertility drugs must be obtained from a designated vendor.* *Drugs for the treatment of infertility services are subject to the combined $10,000 lifetime maximum benefit for infertility services.*	80% of the charges incurred. Deductible must first be satisfied.
Specialty drugs which are self-administered	$15 copayment and 100% thereafter per prescription for generic formulary drugs. $30 copayment and 100% thereafter per prescription for brand formulary drugs. $45 copayment and 100% thereafter per prescription for non-formulary drugs. Deductible does not apply.	80% of the charges incurred. Deductible must first be satisfied.

COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

	Network Benefits	Out-of-Network Benefits
Drugs for the treatment of growth deficiency	$15 copayment and 100% thereafter per prescription for generic formulary drugs. $30 copayment and 100% thereafter per prescription for brand formulary drugs. $45 copayment and 100% thereafter per prescription for non-formulary drugs. Deductible does not apply. *Specialty drugs are limited to drugs on the specialty drug list, and must be obtained from a designated vendor.*	80% of the charges incurred. Deductible must first be satisfied.

Unless otherwise specified above in the Prescription Drug Services section, you may receive up to a 31-day supply per prescription. All drugs are subject to HealthPartners utilization review process and quantity limits. New prescriptions to treat certain chronic conditions are limited to a 31-day supply. In addition, certain drugs may be subject to any quantity limits applied as part of the trial program. A 90-day supply will be covered and dispensed at a time only at pharmacies that participate in the HealthPartners extended day supply program. No more than a 31-day supply of specialty drugs will be covered and dispensed at a time.

If a copayment is required, you must pay one copayment for each 31-day supply or portion thereof, except for mail order drugs, see benefit above.

S. PREVENTIVE SERVICES

1. Routine health exams and periodic health assessments	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible must first be satisfied. $500 annual benefit*
2. Child health supervision services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible must first be satisfied. $500 annual benefit*
3. Routine prenatal services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible must first be satisfied.
4. Routine postnatal services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible must first be satisfied.
5. Routine screening procedures for cancer	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible must first be satisfied. $500 annual benefit*

COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

	Network Benefits	Out-of-Network Benefits
6. Routine eye and hearing exams	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible must first be satisfied. $500 annual benefit*
7. Professional voluntary family planning services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible must first be satisfied. $500 annual benefit*
8. Adult immunizations	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible must first be satisfied. $500 annual benefit*
9. Women's preventive health services (see prescription drug services section for coverage of contraceptive drugs)	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible must first be satisfied. $500 annual benefit*
10. Obesity screening and management	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible must first be satisfied. $500 annual benefit*
		**Limited to $500 maximum benefit per Plan Year combined under Out-of-Network Benefits.*
T. SPECIFIED OUT-OF-NETWORK SERVICES	Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury.	See Network Benefits for the services covered.
U. TRANSPLANT SERVICES	80% of the charges incurred. Deductible must first be satisfied.	80% of the charges incurred. Deductible must first be satisfied.
	Limited to 365 day maximum per period of confinement, subject to the combined day limit.	*Limited to 365 day maximum per period of confinement, subject to the combined day limit.*
V. WEIGHT LOSS SURGERY OR BARIATRIC SURGERY	Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Out-of-Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

CUSTOMER SERVICE

Enrollment and Eligibility Questions	**Office of Student Health Benefits** 410 Church Street SE, Room N323 Minneapolis, MN 55455 Phone: 612-624-0627 or 800-232-9017 (toll-free) Fax: 612-626-5183 or 1-800-624-9881 (toll-free) Email: umshbo@umn.edu http://www.shb.umn.edu
Coverage, Network, and Claims Questions	**HealthPartners Member Services** Phone: 952-883-7500 or 866-270-5434 (toll-free) Medical Residents and Fellows: http://www.healthpartners.com/uofmgme Dental and Veterinary Medicine Residents, Fellows and Interns: http://www.healthpartners.com/uofmres
Emergency Travel Assistance Questions	**FrontierMEDEX** Phone: 800-527-0218 (toll-free) Email: info@medexassist.com http://www.medexassist.com

SPECIFIC INFORMATION ABOUT THE PLAN

Name of the Plan:	The Plan shall be known as the University of Minnesota Residents and Fellows Health Benefit Plan which provides medical benefits.
Address of the Plan:	410 Church Street SE, Room N323 Minneapolis, MN 55455 612-624-0627
Group Number:	25000
Plan Year:	The period beginning on each July 1 in which the provisions of the Plan are in effect.
Plan Sponsor: (is ultimately responsible for the management of the Plan; may employ or contract with persons or firms to perform day-to-day functions such as processing claims and performing other Plan-connected services.)	University of Minnesota
Agent for Service of Legal Process:	General Counsel for University of Minnesota
Named Fiduciary: (has the authority to control and manage the operation and administration of the Plan; has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan.)	University of Minnesota
Funding:	Claims under the Plan are paid from the general assets of the Plan Sponsor.
Plan Manager: (provides administrative services to the Plan Sponsor in connection with the operation of the Plan, such as processing of claims and other functions, as may be delegated to it.)	HealthPartners Administrators, Inc. 8170 33rd Avenue South P.O. Box 1309 Minneapolis, MN 55440-1309 952-883-6000
Network Providers:	HealthPartners Open Access Network
Contributions:	Please refer to the most recent enrollment material for information regarding contributions to your Plan which is hereby incorporated by this reference.

HEALTHPARTNERS MISSION

OUR MISSION IS TO IMPROVE THE HEALTH OF OUR COVERED PERSONS, OUR PATIENTS AND THE COMMUNITY.

ABOUT HEALTHPARTNERS and the PLAN SPONSOR

HealthPartners Administrators, Inc. ("HPAI"). HPAI ("Plan Manager") is a third party administrator (TPA) which is a related organization of HealthPartners, Inc.

HealthPartners, Inc. ("HealthPartners"). HealthPartners is a Minnesota non-profit corporation and managed care organization.

Plan Sponsor. The Plan Sponsor has established a Medical Benefit Plan ("the Plan") to provide medical benefits for Covered Persons. The Plan is "self-insured" which means that the Plan Sponsor pays the claims from its own funding as expenses for covered services as they are incurred. The Plan is described in the Summary of Benefits ("SB"). The Plan Sponsor has contracted with HPAI to provide access to its network of health care providers, claims processing, pre-certification and other Plan administration services. However, the Plan Sponsor is solely responsible for payment of your eligible claims.

Powers of the Plan Sponsor. The Plan Sponsor shall have all powers and discretion necessary to administer the Plan, including, without limitation, powers to: (1) interpret the provisions of the Plan; (2) establish and revise the method of accounting for the Plan; (3) establish rules and prescribe any forms required for administration of the Plan; (4) change the Plan; and (5) terminate the Plan.

The Plan Sponsor, by action of an authorized officer or committee, reserves the right to change the Plan. This includes, but is not limited to, changes to contributions, deductibles, copayments, out-of-pocket maximums, benefits payable and any other terms or conditions of the Plan. The Plan Sponsor's decision to change the Plan may be due to changes in applicable law or for any other reason. The Plan may be changed to transfer the Plan's liabilities to another plan or split the Plan into two or more parts.

The Plan Sponsor shall have the power to delegate specific duties and responsibilities. Any delegation by the Plan Sponsor may allow further delegations by such individuals or entities to whom the delegation has been made. Any delegation may be rescinded by the Plan Sponsor at any time. Each person or entity to whom a duty or responsibility has been delegated shall be responsible for only those duties or responsibilities, and shall not be responsible for any act or failure to act of any other individual or entity.

I. INTRODUCTION TO THE SUMMARY OF BENEFITS

A. SUMMARY OF BENEFITS ("SB")

This SB, along with the Plan Manager's medical coverage criteria (available on-line at www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Dental and Veterinary Residents) or by calling Member Services), is your description of the Medical Benefit Plan ("the Plan"). It describes the Plan's benefits and limitations. Included in this SB is a Schedule of Benefits which states the amount payable for the covered services. Amendments which we include with this SB or send you at a later date are fully made a part of this SB.

This SB should be read completely. Many of its provisions are interrelated; reading just one or two provisions may give you incomplete information regarding your rights and responsibilities under the Plan. Many of the terms used in this SB have special meanings and are specifically defined in the SB. Your SB should be kept in a safe place for your future reference.

The Plan is maintained exclusively for Covered Persons. Each Covered Person's rights under the Plan are legally enforceable. You may not assign or in any way transfer your rights under the Plan.

B. MEDICAL ADMINISTRATIVE SERVICES AGREEMENT ("ASA")

This SB, together with the ASA between the Plan Sponsor and HPAI, as well as any amendments and any other documents referenced in the ASA, constitute the entire agreement between HPAI and the Plan Sponsor. The ASA is available for inspection at the University Of Minnesota Office Of Student Health Benefits or at HealthPartners home office, at 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

C. CONFLICT WITH EXISTING LAW

In the event that any provision of this SB is in conflict with applicable law, that provision only is hereby amended to conform to the minimum requirements of the law.

D. IDENTIFICATION CARD

An identification card will be issued to you at the time of enrollment. You and your Covered Dependents will be asked to present your identification card, or otherwise show that you are a Covered Person, whenever you seek services. You may not permit anyone else to use your card to obtain care.

E. HOW TO USE THE NETWORK

This SB describes your covered services and how to obtain them. **The Plan provides Network Benefits and Out-of-Network Benefits from which you may choose to receive covered services.** Coverage may vary according to your network or provider selection. The provisions below contain information you need to know in order to obtain covered services.

Designated Physician, Provider, Facility or Vendor. This is a current list of network physicians, providers, facilities or vendors which are authorized to provide certain covered services as described in this SB. Call Member Services or visit www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Dental and Veterinary Residents) for a current list.

Network Providers. This is any one of the participating licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies, which have entered into an agreement to provide health care services to Covered Persons. Boynton Health Service is a network provider for this program.

Out-of-Network Providers. These are licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies not participating as network providers.

ABOUT THE NETWORK

To obtain Network Benefits for covered services, you must select and receive services from Network Providers.

Network. This is the network of participating network providers.

Network Clinics. These are participating clinics providing ambulatory medical services.

Continuity of Care. In the event you must change your current primary care physician, specialty care physician or general hospital provider because that provider leaves the network or because your Plan Sponsor changed health plan offerings, you may have the right to continue receiving services from your current provider for a period of time. Some services provided by out-of-network providers may be considered a covered Network Benefit for up to 120 days under this contract if you qualify for continuity of care benefits.

Conditions that qualify for this benefit are:
1. an acute condition;
2. a life-threatening mental or physical illness;
3. pregnancy beyond the first trimester of pregnancy;
4. a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
5. a disabling or chronic condition that is in an acute phase.

You may also request continuity of care benefits for culturally appropriate services or when we do not have a provider who can communicate with you directly or through an interpreter. Terminally ill patients are also eligible for continuity of care benefits.

Call Member Services for further information regarding continuity of care benefits.

Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the authorization process for any services which must first be authorized. You may call the Member Services Department or check on-line at www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Dental and Veterinary Residents) for a list of which services require your physician to obtain prior authorization.

HealthPartners medical or dental directors, or their designees, will determine medical necessity and appropriateness of certain treatments based on established medical policies, which are subject to periodic review and modification.

Your physician will obtain an authorization for (1) residential care for the treatment of eating disorders as an alternative to inpatient care in a licensed facility when medically necessary; (2) psychiatric residential treatment for emotionally handicapped children; and (3) mental health services provided in the home.

You must use a designated convenience care clinic to obtain the convenience care benefit.
You may call Member Services Department or check on-line at www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Dental and Veterinary Residents) for a list.

Durable medical equipment and supplies must be obtained from or repaired by designated vendors.

For Network Benefits, non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility.

To receive Network Benefits, weight loss surgery must be provided by a designated physician.

Multidisciplinary pain management must be provided at designated facilities.

Psychiatric residential treatment for emotionally handicapped children must be provided at designated facilities.

For specialty drugs that are self-administered, you must obtain the specialty drugs from a designated vendor to be covered as Network Benefits.

Call Member Services for more information on authorization requirements or designated vendors.

Second Opinions for Network Services. If you question a decision or recommendation about medical care, the Plan covers a second opinion from an appropriate network provider.

Prescription Drugs and Medical Equipment. Enrolling in the Plan does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment was available previously.

F. CARECHECK®

It is your responsibility to notify CareCheck® of all services requiring review, as shown in 1. below. You can designate another person to contact CareCheck® for you.

1. **CARECHECK® Services.** CareCheck® is HealthPartners utilization review program for out-of-network services. CareCheck® must pre-certify all inpatient confinement and same day surgery, new, experimental or reconstructive outpatient technologies or procedures, durable medical equipment or prosthetics costing over $3,000, home health services after your visits exceed 30 and skilled nursing facility stays. When you call CareCheck®, a utilization management specialist reviews your proposed treatment plan. CareCheck® provides certification and determines appropriate length of stay, additional days and reviews the quality and appropriateness of care.

2. **Procedure To Follow To Receive Maximum Benefits**

   a. **For medical emergencies.** A certification request is to be made by phone to CareCheck® as soon as reasonably possible after the emergency. You will not be denied full coverage because of your failure to gain certification prior to your emergency.

   b. **For medical non-emergencies.** A phone call must be made to CareCheck® when services requiring pre-certification are scheduled, but not less than 48 hours prior to that date. CareCheck® advises the physician and the hospital, or skilled nursing facility, by phone, if the request is approved. This will be confirmed by written notice within 10 days of the decision.

3. **CareCheck® Certification Does Not Guarantee Benefits.** CareCheck® does not guarantee either payment or the amount of payment. Eligibility and payment are subject to all of the terms of the SB. **CareCheck®** only certifies medical necessity.

4. **Information Needed When You Call CareCheck®.**

   When you or another person contacts CareCheck®, this information is needed:
   - the Covered Person's name, address, phone number, birth date and ID number;
   - the attending physician's name, address, and phone number;
   - the facility's name, address, and phone number;
   - the reason for the services requiring review, as shown in a. above.

5. Pre-certification Process.

When a pre-certification for a non-urgent service is requested from HealthPartners, an initial determination must be made within 15 calendar days. This time period may be extended for an additional 15 calendar days, provided that the Plan Manager determines that such extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 15-day period.

When a pre-certification for an urgent service is requested from HealthPartners, an initial determination must be made within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event that the claimant has not provided all information necessary to make a decision, the claimant will be notified of such failure within 24 hours. The claimant will then be given 48 hours to provide the requested information. The claimant will be notified of the benefit determination within 48 hours after the earlier of HealthPartners receipt of the complete information or the end of the time granted to the claimant to provide the specified additional information.

How to contact CareCheck®: You may call **952-883-6400** in the Minneapolis/St. Paul metro area, or toll free at **800-316-9807** (toll-free) outside the metro area, from 8:00 a.m. to 5:00 p.m. (Central Time) weekdays. You can leave a recorded message at other times. You may also write CareCheck® at Quality Utilization Management Department, 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

G. ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, PRE-EXISTING CONDITIONS, OPEN ENROLLMENT, SPECIAL ENROLLMENT PERIODS, SPECIAL RULES RELATING TO MEDICAID AND CHIP, CHANGES IN BENEFITS, TERMINATION, WAIVE COVERAGE, RE-ELECT AFTER WAIVING COVERAGE, MISUSE OF PLAN, CERTIFICATE OF CREDITABLE COVERAGE, CONTINUATION AND RETIREMENT

FOR THE PURPOSES OF THIS SECTION, YOU OR YOUR REFERS TO THE COVERED RESIDENT/FELLOW/INTERN.

1. ELIGIBILITY. For questions on eligibility, contact the Office of Student Health Benefits at (612) 624-0627 or e-mail: umshbo@umn.edu.

The University of Minnesota develops eligibility criteria for its employees and their dependents subject to collective bargaining agreements and compensation plans that may change during a Plan Year. An employee is eligible to participate in the University of Minnesota Residents and Fellows Health Benefit Plan (the Plan) if he/she is working at the University with an appointment in an eligible classification. In no event can a person receive coverage as both an employee and as a dependent of another University of Minnesota Residents and Fellows Health Benefit Plan member. For example, you may not have coverage for yourself as an employee and be a dependent on the coverage of a spouse/registered same-sex domestic partner or a parent who has family coverage as a University of Minnesota resident, fellow or intern. In no event can an employee include a dependent on the Plan who is ineligible for coverage. (See 12. Misuse of Plan.) The Plan reserves the right to request documentation to verify eligibility of your enrolled dependents.

a. Definition of Eligible Dependents

The individuals listed on the chart below and on the following page are considered eligible dependents for the Plan. In addition to specifying criteria for coverage, the chart also includes information as to whether the dependent is considered qualified for favorable tax treatment under the Plan. See Section 2 (below) for further explanation on tax favored and non-tax favored treatment of dependent coverage.

Individuals Eligible as Dependents under the University of Minnesota Residents and Fellows Health Benefit Plan

Relationship to Employee	Criteria for Coverage	Is Dependent Qualified for Tax Favored Treatment (1)
Spouse	**Must be legally married.** Your spouse must not be working full-time for an employer and receiving cash or credits 1) in place of medical coverage or 2) in exchange for medical coverage with a deductible of $750 or greater.	Qualified
Same-Sex Domestic Partner	**Must be registered as same-sex domestic partner.** Your registered same-sex domestic partner must not be working full-time for an employer and receiving cash or credits 1) in place of medical coverage or 2) in exchange for medical coverage with a deductible of $750 or greater.	Usually non-qualified. Refer to same-sex domestic partner information in this definition of eligibility
Dependent Child	**Dependent child —** birth through age 25 (up to the 26th birthday) An eligible child, unmarried or married, can include your biological child, legally adopted child or child placed for the purposes of adoption, foster child, stepchild, or any other child state or federal law requires be treated as a dependent. Note: The spouse of your eligible married dependent child is not eligible for coverage.	Qualified
	Dependent child of registered same sex domestic partner — birth through age 25 (up to the 26th birthday) An eligible child can include your same-sex domestic partner's unmarried or married biological child, legally adopted child or child placed for the purposes of adoption, foster child, stepchild, or any other child state or federal law requires be treated as a dependent. Note: The spouse of your eligible married dependent child is not eligible for coverage.	Usually non-qualified.
	Disabled child — age 18 or above (no maximum) if physically or mentally disabled and either: • lives with you and does not provide over 50% of his/her own support, or • does not live with you but is at least 50% dependent on you	Qualified

(1) "Tax Favored Treatment" refers to how dependent coverage is treated for tax purposes.

b. Tax Favored and Non-Tax Favored Treatment of Dependent Coverage

1) If the right-hand column above is marked "Qualified" for a given dependent category, it means you will pay pre-tax contributions for yourself and any dependents. It also means that the value of the University's contribution to the plan is not considered taxable income to you as the employee.

   a) There are special rules for shared custody situations. Please refer to IRS Publication 501 or to the details of your divorce agreement.

   b) If you are providing over one-half of a child's support for a child who is living with a grandparent, sibling, aunt or uncle, the child is eligible for coverage under the Plan. However, the child is considered the dependent of the custodial individual under IRS rules, and is not eligible for tax favored coverage under the Plan.

2) If the right-hand column above is marked "Non-qualified" for a given dependent category, it means that you will be taxed on the value of the University's contribution for your nonqualified dependent's coverage. This taxable value is called imputed income.

   a) You will also pay the normal pre-tax employee contribution to cover yourself and any other family members. The value of the University's contribution for you and your tax qualified dependents is not considered taxable income to you as the employee.

3) It is your responsibility as the employee to determine whether a dependent is considered to be a qualified or non-qualified dependent for purposes of determining whether coverage is tax favored under the Plan, and to enroll your dependent in the correct manner. One general guideline is that if the child is considered your dependent for tax purposes, he/she is eligible for coverage on a tax-favored basis. Notice of any change in dependent tax status must be communicated to the University within 30 days of the change.

4) There are special rules about taxation of coverage for "Non-qualified" dependents that apply in limited circumstances:

   a) When a part time employee pays the full cost of coverage on a pre-tax basis, the cost of coverage for the "Non-qualified" dependent would still be considered imputed income for the employee because the coverage is otherwise being paid on a pre-tax basis.

   b) When an early retiree or disabled participant pays the full cost of coverage on an after-tax basis and has a "Non-qualified" dependent child, there is no additional taxable income requirement because the plan member is already paying the full cost of coverage.

   c) When a former employee pays a portion of the cost of coverage on an after-tax basis and has a "Non-qualified" dependent child, the cost of coverage for the child in excess of the after-tax payment would be taxable to the former employee. This amount would be reported on a W-2 form.

c. Eligible Dependent Children

1) An eligible child, unmarried or married, can include your own biological child, legally adopted child, or child placed for the purposes of adoption, foster child, stepchild, and any other child state or federal law requires be treated as a dependent. Eligible child can also include the child of your registered same-sex domestic partner, although that coverage is generally not available on a tax favored status.

   a) The date of placement for a child who is being adopted means the assumption and retention by a person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.

b) To be considered a dependent child, a foster child must be dependent on you for his/her principal support and maintenance, and must be placed by the court in your custody.

c) To be considered a dependent child, a stepchild must be dependent on you for his/her principal support and maintenance. In addition, the stepchild must maintain residence with you or must not be a dependent child of any other individual for tax purposes. A stepchild means the child of your spouse by a previous marriage/partnership.

Note: The spouse of your eligible married dependent child is not eligible for coverage.

2) The child of your same-sex domestic partner can be considered a dependent child if your same-sex domestic partner is registered with the University and the child meets all other requirements for an eligible child. This applies to both the children of your registered same-sex domestic partner from your current partnership or his/her previous marriage/partnership.

"Principal support" means more than half of the dependent child's support.

3) If both you and your spouse/registered same-sex domestic partner work for the University of Minnesota, then either of you, but not both, may cover your eligible dependent children/ grandchildren. This also applies to two divorced or unmarried employees who share legal responsibility for their dependent children or grandchildren.

4) Your grandchild is eligible for coverage if he/she is your tax-dependent; if the grandchild is placed in your legal custody; or if the grandchild is legally adopted or placed with you for the purpose of adoption. The grandchild must be dependent upon you for more than one-half of his/her support and you must claim the grandchild as a dependent on your tax return.

d. Eligibility of Spouse/Registered Same-sex Domestic Partner

If both you and your spouse/registered same-sex domestic partner work for the University of Minnesota, then either of you has the option of adding the other as a dependent to his/her family coverage. The spouse/registered same-sex domestic partner added to the family coverage must waive employee coverage.

However, if your spouse or registered same-sex domestic partner works full-time for an employer and receives cash or credits (1) in place of medical coverage, or (2) in exchange for a medical coverage with a deductible of $750 or greater, then he/she is not considered to be an eligible dependent under the Plan.

Same-sex domestic partner registration criteria:

1) Engaged in a committed relationship and intend to remain together indefinitely;

2) Are the same sex and for this reason are unable to marry each other under Minnesota law;

3) Are at least 18 years of age and have the capacity to enter into a contract;

4) Are jointly responsible to each other for the necessities of life; and

5) Are not related by blood closer than permitted under Minnesota marriage laws.

Visit the Office of Student Health Benefits website for the forms to register your same-sex domestic partner at www.shb.umn.edu.

e. Taxability of Coverage for your Registered Same-sex Domestic Partner and the Child/ Children of Registered Same-sex Domestic Partner

Under IRS rules, the value of the medical and dental coverage provided by the University to your registered same-sex domestic partner and the child/children of your registered same-sex domestic partner is generally considered taxable income to you as the employee. The only exception to the

taxability of these benefits is if your registered same-sex domestic partner and his or her children meet the following IRS definition of a dependent.

A registered same-sex domestic partner and his/her children can meet the definition of a dependent for the purposes of family coverage if the following conditions are met:

1) They lived with you for the entire year as a member of your household,

2) They were U.S. citizens or resident aliens of the U.S. or residents of Canada or Mexico for part of the calendar year in which your tax year began,

3) They did not file a joint tax return,

4) You provided over half of their support for the calendar year, and

5) They are not a dependent child for tax purposes of any other individual.

If your registered same-sex domestic partner and children meet all of the above requirements, you will need to complete a Certification of Dependent Status form. Information and the form can be found on the Office of Student Health Benefits website at www.shb.umn.edu. Note: Most same-sex domestic partner expenses are not eligible to be reimbursed through the HSA, per IRS regulations.

f. Coverage of Disabled Children of Any Age

1) Your dependent child of any age is eligible for coverage and tax favored status if he/she is incapable of self-sustaining employment by reason of mental retardation, mental illness, mental disorder, or physical disability, and is chiefly dependent upon you for his/her support and maintenance (meaning you provide for more than one-half of the child's support).

2) A dependent child must be certified by the University of Minnesota Residents and Fellows Health Benefit Plan Administrator to be disabled prior to age 26, based on proof that the child meets the above requirements.

   a) If for any reason, you drop coverage for a disabled dependent prior to age 26, then wish to cover the child again, coverage must be added prior to the child turning age 26, and his/her disabled status recertified by the Plan Administrator.

   b) Once your disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility.

3) A disabled dependent child who is 26 years of age or older and unmarried at the time of your initial eligibility for coverage in the Plan, may be enrolled for coverage if:

   a) You (the employee) enroll for coverage during your initial eligibility period, and;

   b The University of Minnesota Residents and Fellows Health Benefit Plan Medical Plan Administrator certifies that the dependent meets the above requirements.

   Proof of disability status must be provided within 31 days of your initial date of eligibility and enrollment in the Plan. The disabled dependent shall be eligible for coverage as long as he/she continues to be disabled and dependent, unless coverage otherwise terminates under the Plan.

   A dependent child who is considered to be disabled by the University of Minnesota Residents and Fellows Health Benefit Plan Administrator will be eligible for tax favored coverage under the Plan, regardless of age. The disabled child of a registered same-sex domestic partner will not be eligible for tax favored coverage.

g. Children Covered by Child Support Order

Children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order are eligible, as required by federal and state law to assure that children who do not live with both of their biological parents have adequate medical coverage. This provision does not apply to children of the spouse/registered same-sex domestic partner who are not also children of the employee.

h. Not Eligible

For purposes of coverage under the Plan, your parents, grandparents, in-laws, brothers, sisters, cousins and other extended family members, non-registered same-sex domestic partners and their children, and unmarried opposite-sex domestic partners and common-law spouses are not eligible dependents.

i. Family Status Change

To make changes in your medical, dental, optional life coverage, or flexible spending accounts after you are first eligible or outside of the annual open enrollment period, you must have a change in family status. The coverage change must be consistent with the family status change. A request for change in your coverage due to a family status change must be made within 30 days of the date of change. Failure to apply for a change in coverage within 30 days of the family status change means that you will not be able to make a change until the next available open enrollment period.

Family status changes include:

- Change in legal marital status, including marriage, divorce, or annulment.
- Registration of your same-sex domestic partnership or termination of same-sex domestic partnership.
- Death of your spouse/registered same-sex domestic partner or last eligible dependent child.
- Birth or adoption of your eligible dependent child.
- Change in last dependent child's eligibility because of age.
- Commencement or termination of employment for you, spouse/registered same-sex domestic partner, or dependent.
- Changes in your or your spouse/registered same-sex domestic partner's employment status from part-time to full-time or from full-time to part-time.
- Change in the place of residence or worksite for you, spouse/registered same-sex domestic partner, or dependent to a location outside of the current plan's service area and the current plan is not available.

2. ENROLLMENT. You must complete your enrollment for yourself and any eligible dependents within 14 days of date of hire. Payroll deductions will be based on your effective date of coverage not on the date your enrollment was completed. Failure to enroll within 14 days will result in no coverage for you and any eligible dependents. However, you will be permitted to enroll at the next Open Enrollment or sooner in the event of a qualified change in family status (see G. Midyear Enrollment Due to Status Change). All persons eligible for coverage must enroll to obtain coverage under the health care plan. Enrollment cannot be accomplished through the online registration process. To enroll you must fill out the enrollment forms available on the Office of Student Health Benefits website at www.shb.umn.edu. Return the forms, by mail, fax, or in person, to the Office of Student Health Benefits at 410 Church Street S. E. Room N323 Minneapolis, MN 55455 or fax: 612-626-5183 or 1-800-624-9881. The sooner you enroll the sooner you will receive an identification card that shows your eligibility for health care. (If you need health care before receiving the card, your health care provider may contact the Office of Student Health Benefits to verify your enrollment and eligibility.)

You must complete your enrollment for a newly acquired eligible dependent within 30 days of when you first acquire the dependent (e.g., through marriage or registration of a same-sex domestic partner). Payroll deductions will be based on the effective date of coverage not on the date your enrollment was completed. Failure to enroll within 30 days will result in no coverage for the newly acquired dependent. The next opportunity to enroll the dependent will be at Open Enrollment or sooner in the event of a qualified change in family status (see G. Midyear Enrollment Due to Status Change.

3. EFFECTIVE DATE.

a. The initial effective date of coverage is determined by the Plan Sponsor.

b. If you and your dependents apply for coverage during an open enrollment period, coverage will become effective on July 1 of the following year.

c. A newborn child's coverage takes effect from the moment of birth.

d Adopted children are covered from the date of placement for the purposes of adoption.

e. Disabled dependents are covered from your effective date of coverage.

f. For the purposes of this entire section, a dependent's coverage may not take effect prior to an employee's coverage.

4. PRE-EXISTING CONDITIONS. The Plan does not have a pre-existing condition clause. This means that you and your eligible dependents will have coverage for any medical condition, including pregnancy, as soon as your coverage becomes effective. This applies to both new employees and employees who make plan changes during open enrollment.

5. OPEN ENROLLMENT. During the University of Minnesota Residents and Fellows Health Benefit Plan annual Open Enrollment period you may change medical plans, enroll in coverage for yourself, waive coverage with proof of other coverage, and add or drop dependents from your coverage for the upcoming plan year.

6. SPECIAL ENROLLMENT PERIODS.

a. Midyear Enrollment Due to Status Change
If you have a status change and fail to enroll within the times listed below, you will lose that opportunity and cannot make a change until the next Open Enrollment period. Please take note of the time frames allowed for you to make midyear enrollment changes.

You may add coverage within your selected University of Minnesota Residents and Fellows Health Benefit Plan medical plan option for all eligible dependents **within 30 calendar days** of the following events:

1) You legally marry or you register your same-sex domestic partner.

2) If your dependent spouse/same-sex domestic partner loses group coverage, you may add family coverage. Loss of coverage includes any change in coverage that results in termination of your dependent's coverage, even if it is immediately replaced by other subsidized coverage.

You must complete enrollment within 30 days of the date of loss of coverage in order to be eligible under this provision. You must also provide a statement from the former medical plan Administrator documenting the loss of coverage.

Loss of coverage does not include the following:

1) A change in medical plan Administrators through the same employer where the coverage is continuous and uninterrupted;

2) A change in your dependent's medical plan benefit levels; and

3) A voluntary termination of coverage by your dependent, including, but not limited to termination or reduction of coverage due to the adoption of cafeteria-style plans.

4) When you acquire a dependent child. In addition, at this time you can add your spouse/registered same-sex domestic partner and any other eligible dependent children who have not been covered under the University of Minnesota Residents and Fellows Health Benefit Plan.

5) When your dependent child to age 26 meets the eligibility criteria described in the chart in A. Eligibility.

b. Midyear Change to Medical Plan Selection

You and your dependents may be allowed to make a change to your medical plan selection outside of the initial period of eligibility or annual open enrollment. The midyear plan selection enrollment must occur within 30 calendar days of the status changes specified below.

1) Any Plan Administrator participating in the University of Minnesota University of Minnesota Residents and Fellows Health Benefit Plan is placed into reorganization or liquidation or is otherwise unable to provide the services specified in the Summary of Benefits.

2) Any Plan Administrator participating in the University of Minnesota University of Minnesota Residents and Fellows Health Benefit Plan loses all or a portion of its primary care provider network (including Hospitals) to the extent that primary care services are not accessible or available within 30 miles of your work location or residence.

3) Any Plan Administrator participating in the University of Minnesota University of Minnesota Residents and Fellows Health Benefit Plan terminates or is terminated from participation in the University of Minnesota Residents and Fellows Health Benefit Plan.

4) The University of Minnesota approves a request from an employee due to an administrative error that occurs during the open enrollment process.

5) An enrollee moves or is transferred to a location outside of the current plan's service area and his/her current plan is not available.

6) Retirees may elect to change to another University of Minnesota Residents and Fellows Health Benefit Plan medical plan in the **60 days** immediately preceding the effective date of retirement.

c. Adding New Dependents

Enrollment is required to add a new dependent. Filing a claim for benefits is not sufficient notice to add a dependent. This part outlines the time periods for enrollment and the date coverage starts. See B. Effective Date of Coverage for when coverage is effective.

1) Adding a spouse/same-sex domestic partner.

A spouse/same-sex domestic partner is eligible on the date of legal marriage/University of Minnesota Declaration of Same-Sex Domestic Partnership registration.

You must complete enrollment within 30 days after the legal marriage/registration of same-sex domestic partner for coverage to become effective on the date of legal marriage/registration of same-sex domestic partner. Deductions for the appropriate level of family coverage will begin with the first day of the coverage that includes the date of legal marriage/registration of same-sex domestic partner.

2) Adding newborns.

Coverage will become effective on the date of birth. Enrollment for coverage should be completed within 30 days of the date of birth. Failure to enroll will not alter the effective date of coverage; however, it will result in claim service problems for the child.

3) Adding children placed for adoption.

Coverage will take effect on the date of placement. Enrollment for coverage should be completed within 30 days from the date of placement.

In all cases, application for coverage under the Plan must be made within 30 days of the event permitting enrollment and must include the following information: name, date of birth, gender, Social Security number, and relationship to the employee.

d. HIPAA Special Enrollment Rights Changes

You may also make changes to your election if you or your dependent decline coverage under the University of Minnesota Residents and Fellows Health Benefit Plan and later experience a HIPAA Special Enrollment right. You must request to make an election change within 30 days of the event, with the exception of losing eligibility for Medicaid/CHIP coverage or qualifying for state assistance, in which case you have 60 days from the event or notification to make an election change. The Special Enrollment opportunities are:

- Loss of eligibility for coverage under another plan
- Loss of employer contribution to another group health plan
- Gaining a dependent through marriage, birth, adoption, or placement for adoption
- Loss of eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP)
- Qualification for state assistance in paying group health plan premiums
- The plan is terminated
- Continuation coverage under COBRA ends, other than for failure to pay premiums

During the University of Minnesota Residents and Fellows Health Benefit Plan annual Open Enrollment period you may change medical plans, enroll in coverage for yourself, waive coverage with proof of other coverage, and add or drop dependents from your coverage for the upcoming plan year.

7. SPECIAL RULES RELATING TO MEDICAID AND CHIP

In General – a Covered Person, who is eligible, but not enrolled for coverage under the terms of the Plan, may enroll for coverage under the terms of the Plan if either of the following conditions is met:

a. TERMINATION OF MEDICAID OR CHIP COVERAGE – you or your dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a state child health plan under title XXI of such Act and coverage of you or your dependent under such plan is terminated as a result of loss of eligibility for such coverage and you request coverage under the Plan not later than 60 days after the date; or

b. ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP – you or your dependent becomes eligible for assistance, with respect to coverage under the Plan, under such Medicaid plan or state child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if you request coverage under the Plan not later than 60 days after the date you or dependent is determined to be eligible for such assistance.

8. CHANGES IN BENEFITS. Any change in benefits is subject to the Plan Sponsor's approval. If a change in benefits is requested by the Plan Sponsor or the Plan Manager, it is effective on the date they agree to. Any change in benefits required by law becomes effective according to law.

9. TERMINATION.

If you or your dependent(s) no longer meet the University of Minnesota University of Minnesota Residents and Fellows Health Benefit Plan's eligibility requirements and you fail to timely notify the Plan Administrator, or if the University of Minnesota University of Minnesota Residents and Fellows Health Benefit Plan has forwarded enrollment for an employee or dependent to the Plan Administrator,

regardless of whether such employee or dependent meets his/her eligibility requirements, the date of coverage termination depends on whether the employee contribution payments have been made. If no or inadequate employee contribution payments have been made (including failure to make full continuation contribution payments for ineligible dependents), the coverage will be retroactively terminated to the date of loss or lack of eligibility. If full employee contribution payments have been made (including full continuation contribution payments), the University of Minnesota University of Minnesota Residents and Fellows Health Benefit Plan may terminate coverage prospectively.

During the period for which payment has been made, the University of Minnesota University of Minnesota Residents and Fellows Health Benefit Plan is required to keep the coverage in place and to pay the University's contribution for that coverage, and the employee is required to make his/her employee contribution payment.

Coverage for you and/or your dependents will terminate on the earliest of the following dates, except that coverage may be continued or converted in some instances as specified in 14. Continuation.

a. For you and your dependents, the date that either the Plan Administrator or the University of Minnesota terminates the Plan.
b. For you and your dependents, the last day of the month in which you retire, unless you and your dependents are eligible for and elect to maintain coverage under this Plan or a separate Medicare contract.
c. For you and your dependents, the last day of the month in which your eligibility under this Plan ends.
d. For you and your dependents, the last day of the month following the receipt of a written request by you to cancel coverage. Approval to terminate coverage will only be granted if the request is consistent with a status change. Status changes include, but are not limited to:
    1) loss of dependent status of a sole dependent;
    2) death of a sole dependent;
    3) divorce/notice of termination of same-sex domestic partnership;
    4) change in employment condition of an employee or spouse/same-sex domestic partner;
    5) a significant change of spouse/same-sex domestic partner insurance coverage (cost of coverage is not a significant change); and
    6) during an open enrollment.

In the event that you experience one of these status changes, you are obligated to contact the Office of Student Health Benefits within 30 days.

e. For a child covered as a dependent, the last day of the month in which the child is no longer eligible as a dependent, unless otherwise specified by the University of Minnesota.
f. For a dependent, the effective date of coverage, if the employee or his/her dependent knowingly makes fraudulent misstatements regarding the eligibility of the dependent for coverage.
g. For an enrollee who is directly billed by the University of Minnesota, the last day of the month for which the last full payment was received, if the enrollee fails to make full payment within 30 days of the date the bill was due, whichever is later.
h. For any enrollee who is directly billed by the Plan Administrator and/or COBRA Administrator, the last day of the month for which the last payment was received, if the enrollee fails to make full payment within 30 days of the date the bill was due. Enrollees include COBRA participants, disabled participants, and retirees under age 65.
i. For a retiree and/or dependent over age 65 who terminates Medicare Part B Coverage, or who fails to apply for Medicare Part B Coverage within 30 days of the effective date of retirement, within 30 days after the retiree or dependent receives notice from the Plan Administrator.

10. WAIVE COVERAGE

You have the option as a new employee and during Open Enrollment to waive coverage, by completing a health plan waiver request form.

The following status change events also allow you to waive or decrease medical coverage midyear:

- Your legal marriage/University of Minnesota Declaration of Domestic Partnership registration terminates

- You gain medical coverage through your spouse/same-sex domestic partner.

If you decide to waive coverage as a result of a status change event, you must waive coverage **within 30 days** of the qualifying event. Failure to waive coverage within 30 days of the event will result in not being able to make changes until the following Open Enrollment.

11. RE-ELECT COVERAGE AFTER WAIVING COVERAGE

If you waived medical coverage, you can elect medical coverage again during the next open enrollment period, or midyear as a result of the following status change events:

- Your legal marriage/University of Minnesota Declaration of Domestic Partnership registration
- The birth or adoption of your child
- The death of your spouse/same-sex domestic partner or last dependent child
- Your divorce/notice of termination of domestic partnership
- You lose coverage through your spouse/same-sex domestic partner
- You experience a significant change in employer contributions
- Your dependent child to age 26 meets eligibility criteria as stated in the chart in A. Eligibility

If you decide to re-elect coverage as a result of a status change event, you must enroll **within 30 days** of the qualifying event. Failure to enroll within 30 days of the event will result in not being able to make changes until the following Open Enrollment.

12. MISUSE OF PLAN

You will be subject to disciplinary action up to and including loss of coverage and termination of employment if you:

a. submit fraudulent, altered, or duplicate billings for any reason, including but not limited to submissions for personal gain;

b. enroll or allow another party who is not eligible or covered under this Plan to use your coverage or plan identification to obtain coverage;

c. fail to notify The Office of Student Health Benefits on a timely basis of loss of eligibility for your dependents; or

d. provide false, incorrect or fraudulent information on your enrollment, including your enrollment of dependents.

30-day notice is required to retroactively terminate coverage under the University of Minnesota University of Minnesota Residents and Fellows Health Benefit Plan for intentional misrepresentation or gross misconduct.

13. CERTIFICATE OF CREDITABLE COVERAGE

When you or your dependents terminate coverage under the Plan, a certification of creditable coverage form will be issued to you from your Plan Administrator specifying your coverage dates under the medical plan and any probationary periods you are required to satisfy. The certification of creditable coverage form will contain all the necessary information another medical plan will need to determine if you have prior continuous coverage that should be credited toward any pre-existing condition limitation period. Medical plans may require that you submit a copy of this form when you apply for coverage.

The certification of creditable coverage form will be issued to you when you terminate coverage with the University of Minnesota Residents and Fellows Health Benefit Plan, and, if applicable, at the expiration of any continuation period. The Plan Administrator will also issue the certification of creditable coverage form if you request an additional copy at any time within the 24 months after your coverage terminates.

14. CONTINUATION

You or your Covered Dependents may continue coverage under this Plan if current coverage ends because of any of the qualifying events listed on the following page. You or your dependent must be covered under the Plan before the qualifying event in order to continue coverage. In all cases, continuation ends if the University of Minnesota Residents and Fellows Health Benefit Plan ends or required charges are not paid when due.

The following section generally describes continuation coverage under this Plan. Also refer to the COBRA Notice for more information.

Qualifying Event	Who May Continue	Maximum Continuation Period
Employment ends, certain leaves of absence, layoff, or reduction in hours (except gross misconduct coverage, dismissal)	Employees and dependents	Earlier of: 1. Enrollment date in other group, or 2. 18 months
Divorce	Former spouse and any dependent children who lose coverage	Earlier of: 1. 36 months from the date of divorce 2. Enrollment in other group coverage, or 3. Date coverage would otherwise end
Termination of Same-Sex Domestic Partnership	Former same-sex domestic partner and any dependent children who lose coverage	Earlier of: 1. 36 months from the date of termination of same-sex domestic partnership 2. Enrollment in other group coverage, or 3. Date coverage would otherwise end
Death of employee	Surviving spouse/same-sex domestic partner and dependent children coverage	Earlier of: 1. Enrollment date in other group, or 2. Date coverage would otherwise end
Dependent child loses eligibility	Dependent child	Earlier of: 1. 36 months from the date of losing eligibility, 2. Enrollment in other group coverage, or 3. Date coverage would otherwise end
Employee retires at age 65 or over and enrolls in Medicare Part A, Part B, or both	Employee and dependents	Earliest of: 1. 36 months from date of enrollment in Medicare 2. Enrollment in other group coverage, or 3. Date coverage would otherwise end
Surviving dependent of retiree on lifetime continuation due to bankruptcy of Employer	Surviving spouse and dependents	36 months following retiree's death
Total disability* Earlier of:	Employee and dependents	1. Date total disability ends, or 2. Date coverage would otherwise end
Total disability of dependent**	Dependent	Earliest of: 1. 18 months, or 2. 29 months after the employee leaves employment, or 3. Date total disability ends, or 4. Date of enrollment in Medicare, or 5. Date coverage would otherwise end

* Total disability means the employee's inability to engage in or perform the duties of the employee's regular occupation or employment within the first two (2) years of the disability. After the first two (2) years, it means the employee's inability to engage in any paid employment or work for which the employee may, by education and training, including rehabilitative training, be or reasonably become qualified. For employees disabled prior to January 1, 1992, total disability means the employee's inability to engage in or perform the duties of the employee's regular occupation or employment from the date of disability.

** If the dependent is disabled at the time the employee leaves employment or becomes disabled within the first 60 days of continuation of coverage, continuation for the dependent may be extended beyond the 18 months of continuation. In order to qualify, the disabled dependent must meet the following notice requirements during the 18 months of continuation:

- The dependent must apply for Social Security benefits and be determined to have been totally disabled at the time of the qualifying event or within the first 60 days of continuation of coverage.

- The dependent must notify the COBRA Administrator of the disability determination within 60 days after the disability determination.

a. Choosing continuation

If you lose coverage, the Plan will notify you within 14 days after employment ends of the option to continue coverage. If coverage for your dependent ends because of divorce, termination of same-sex domestic partnership, or any other change in dependent status, you or your Covered Dependents must notify the Office of Student Health Benefits in writing within 30 days after the qualifying event occurs.

You or your Covered Dependents must choose to continue coverage by notifying the Plan by completing an application. You or your Covered Dependents have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or your Covered Dependents ineligible to choose continuation at a later date.

You or your Covered Dependents have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your Covered Dependents must pay charges monthly in advance to the COBRA administrator to maintain coverage in force.

Charges for continuation are the University of Minnesota Residents and Fellows Health Benefit Plan group rate plus a two-percent (2%) administration fee. (If the qualifying event for continuation is the employee's total disability, the administration fee is not required.) All charges are paid according to the instructions in the COBRA and state Continuation Coverage form.

b. Additional qualifying events

If additional qualifying events occur during continuation, dependent qualified beneficiaries may be entitled to election rights of their own and an extended continuation period. This only applies when the initial qualifying event for continuation is the employee's termination of employment, reduction in hours, retirement, leave of absence or layoff.

When a second qualifying event occurs, such as the death of the former Covered Employee, the dependent must notify the employer of the additional event within 31 days after it occurs in order to continue coverage. Continuation charges must be paid in the same manner as for the initial qualifying event.

A qualified beneficiary is any individual covered under the medical plan the day before the qualifying event, as well as a child who is born or placed for adoption with the Covered Employee during the period of continuation of coverage.

c. Special rule for pre-existing condition continuation

If you or your Covered Dependents obtain other group coverage that excludes benefits for pre-existing conditions, you or your Covered Dependents may choose to remain on continuation for a pre-existing

condition until the date continuation would otherwise end or until the pre-existing clause of the new plan is met, whichever occurs first. This Plan is primary and determines benefits first for the pre-existing condition. This Plan is not primary for any other condition. For a newborn child born during continuation, the other plan is primary starting on the date of birth.

d. Cost verification

The University will provide you or your eligible dependents, upon request, written verification of the cost of continuation coverage at the time of eligibility or at any time during the continuation period.

II. DEFINITIONS OF TERMS USED

Admission. This is the medically necessary admission to an inpatient facility for the acute care of illness or injury.

Brand Drug. A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand drug has expired. A few brand drugs may be covered at the generic benefit level if it is indicated on the formulary.

CareCheck® Service. This is a pre-certification and utilization management program. It reviews, authorizes and coordinates the appropriateness and quality of care for certain benefits, as covered under the Out-of-Network Benefits of the Plan.

CareLine℠ Service. This is a 24-hour telephone service which employs a staff of registered nurses who are available by phone to assist Covered Persons in assessing their need for medical care, and to coordinate after-hours care, as covered under the Plan.

Clinically Accepted Medical Services. These are techniques or services that have been determined to be effective for general use, based on risk and medical implications. Some clinically accepted medical services are approved only for limited use, under specific circumstances, as more fully described in this SB.

Convenience Clinic. This is a clinic that offers a limited set of services and does not require an appointment.

Cosmetic Surgery. This is surgery to improve or change appearance (other than reconstructive surgery), which is not necessary to treat a related illness or injury.

Covered Dependent. This is the eligible dependent enrolled in the Plan.

Covered Resident/Fellow. This is the eligible resident or fellow enrolled in the Plan.

Covered Person. This is the eligible and enrolled resident/fellow and each of his or her eligible and enrolled dependents covered for benefits under the Plan. When used in this SB, "you" or "your" has the same meaning as Covered Person.

Covered Service. This is a specific medical or dental service or item, which is medically necessary or dentally necessary and covered by the Plan, as specifically described in this SB.

Custodial Care. This is a supportive service focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to, bathing, dressing and feeding.

Dentally Necessary. This is care which is limited to diagnostic testing, treatment, and the use of dental equipment and appliances which, in the judgment of a dentist, is required to prevent deterioration of dental health, or to restore dental function. The Covered Person's general medical condition must permit the necessary procedure(s).

Dentist. A duly licensed doctor of dental surgery or dental medicine, lawfully performing a dental service in accordance with governmental licensing privileges and limitations.

Eligible Dependents. See Section II. "Coverage Eligibility and Enrollment".

Emergency Accidental Dental Services. These are services required immediately, because of a dental accident (See subsection E. Dental Services under Section IV. Description of Covered Services).

Effective Date. This means the first day of coverage under the health benefit plan.

Facility. This is a licensed medical center, clinic, hospital, skilled nursing facility or outpatient care facility, lawfully providing a medical service in accordance with applicable governmental licensing privileges and limitations.

Fiduciary. The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.

Formulary. This is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies covered under the Plan as indicated in the Schedule of Benefits which are covered at the highest benefit level. Some drugs may require authorization to be covered as formulary drugs. The formulary, and information on drugs that require authorization, are available on-line at www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Dental and Veterinary Residents) or by calling Member Services.

Generic Drug. A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand drug. Generally, generic drugs cost less than brand drugs. A few brand drugs may be covered at the generic benefit level if it is indicated on the formulary.

Habilitative Care. This is speech, physical or occupational therapy which is rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development. To be considered habilitative, measurable functional improvement and measurable progress must be made toward achieving functional goals, within a predictable period of time toward a Covered Person's maximum potential ability. The determination of whether such measurable progress has been made is within the sole discretion of the Plan's medical director or his or her designee, based on objective documentation.

Health Care Provider. This is any licensed non-physician (excluding naturopathic providers), lawfully performing a medical service in accordance with applicable governmental licensing privileges and limitations, who renders direct patient care to Covered Persons as covered under the Plan.

Home Hospice Program. This is a coordinated program of home-based, supportive and palliative care, for terminally ill patients and their families, to assist with the advanced stages of an incurable disease or condition. The services provided are comfort care and are not intended to cure the disease or medical condition, or to prolong life, in accordance with an approved home hospice treatment plan.

Hospital. This is a licensed facility, lawfully providing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility under the Plan. A hospital is not a nursing home, or convalescent facility.

Inpatient. This is a medically necessary confinement for acute care of illness or injury, other than in a hospital's outpatient department, where a charge for room and board is made by the hospital or skilled nursing facility. The Plan covers a semi-private room, unless a physician recommends that a private room is medically necessary. In the event a Covered Person chooses to receive care in a private room under circumstances in which it is not medically necessary, payment under the Plan toward the cost of the room shall be based on the average semi-private room rate in that facility.

Investigative. As determined by HealthPartners, a drug, device or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness or effect on health outcomes. The following categories of reliable evidence will be considered, none of which shall be determinative by itself:

1. Whether there is final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the U.S. Food and Drug Administration (FDA); if the drug or device or medical treatment or procedure is the subject of ongoing

Phase I, II or III clinical trials; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and

2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in the American Hospital Formulary Service as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility studying the same drug, device, medical treatment or procedure.

Medically Necessary/Medically Necessary Care. This is health care services that are appropriate in terms of type, frequency, level, setting and duration to your diagnosis or condition, diagnostic testing and preventive services. Medically necessary care, as determined by the Plan, must be:

1. Appropriate for the symptoms, diagnosis or treatment of your medical condition;
2. Consistent with evidence-based standards of medical practice where applicable;
3. Not primarily for your convenience or that of your family, your physician, or any other person; and
4. The most appropriate and cost-effective level of medical services or supplies that can be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided in a lower level of care setting.

The fact that a physician, participating provider, or any other provider, has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed you of its availability, does not in itself make it medically necessary.

Medicare. This is the federal government's health insurance program under Social Security Act Title XVIII, as amended. Medicare provides medical benefits to people who are 65 or older, or who are permanently disabled. The program has two parts: Part A and Part B. Part A generally covers the costs of hospitals and extended care facilities. Part B generally covers the costs of professional medical services. Both parts are subject to Medicare deductibles.

Mental Health Professional. This is a psychiatrist, psychologist, or mental health therapist licensed for independent practice, lawfully performing a mental or chemical health service in accordance with governmental licensing privileges and limitations, who renders mental or chemical health services to Covered Persons as covered under the Plan. For inpatient services, these mental health professionals must be working under the order of a physician.

Non-Formulary Drug. This is a prescription drug which is not on the formulary, is medically necessary and is not investigative or otherwise excluded under this Plan.

Outpatient. This is medically necessary diagnosis, treatment, services or supplies rendered by a hospital's outpatient department, or a licensed surgical center and other ambulatory facility (other than in a physician's office).

Period of Confinement. This is (1) one continuous hospitalization, or (2) a series of hospitalizations or skilled nursing facility stays, or periods of time when the Covered Person is receiving home health services, for the same medical condition in which the end of one is separated from the beginning of the next by less than 90 days. For the purpose of this definition, "same condition" means illness or injury related to former illness or injury in that it is either within the same ascertainable diagnosis or set of diagnoses, or within the scope of complications or related conditions.

Physician. This is a licensed medical doctor, or doctor of osteopathy, lawfully performing a medical service, in accordance with governmental licensing privileges and limitations who renders medical or surgical care to Covered Persons as covered under the Plan.

Plan Year. The plan year is the period beginning at 12:01 A.M. Central Time, on July 1, 2013, and ending 12:00 A.M. Central Time June 30, 2014. All subsequent plan years will begin at 12:01 A.M. Central Time, on July 1, and ending 12:00 A.M. Central Time June 30.

Prescription Drug. This is any medical substance for the prevention, diagnosis or treatment of injury, disease or illness approved and/or regulated by the U.S. Food and Drug Administration (FDA). It must (1) bear the legend: "Caution: federal law prohibits dispensing without a prescription" or "Rx Only"; and (2) be dispensed only by authorized prescription of any physician or legally authorized health care provider under applicable state law.

Pre-service Claim. This is any claim for a benefit under a group health plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. The only claims under this Plan that meet this definition are those claims that require pre-certification by CareCheck®.

Reconstructive Surgery. This is limited to reconstructive surgery, incidental to or following surgery, resulting from injury or illness of the involved part, or to correct a congenital disease or anomaly resulting in functional defect in a dependent child. A functional defect is one that interferes with a Covered Person's ability to perform activities of daily living.

Rehabilitative Care. This is a restorative service, which is provided for the purpose of obtaining significant functional improvement, within a predictable period of time, (generally within a period of two months) toward a patient's maximum potential ability to perform functional daily living activities.

Skilled Nursing Facility. This is a licensed skilled nursing facility, lawfully performing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility by the Plan, to render inpatient post-acute hospital and rehabilitative care and services to Covered Persons, whose condition requires skilled nursing facility care. It does not include facilities which primarily provide treatment of mental or chemical health.

Specialty Drug List. This is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies, which are typically bio-pharmaceuticals. The purpose of a specialty drug list is to facilitate enhanced monitoring of complex therapies used to treat specific conditions. The specialty drug list is available on-line at www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Dental and Veterinary Residents) or by calling Member Services.

Virtuwell. Virtuwell is an online service that you use to receive a diagnosis and treatment for certain routine conditions, such as a cold and flu, ear pain and sinus infections. You may access the virtuwell website at www.virtuwell.com.

III. DESCRIPTION OF COVERED SERVICES

The Plan covers the services described below and on the Schedule of Benefits. The Schedule of Benefits describes the level of payment that applies for each of the covered services. To be covered under this section, the medical or dental services or items described below must be medically necessary or dentally necessary.

Coverage is subject to the exclusions, limitations, and other conditions of this SB.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. These medical policies (medical coverage criteria) are available on-line at www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Dental and Veterinary Residents) or by calling Member Services.

A. ACUPUNCTURE

The Plan covers acupuncture services when medically necessary.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available on-line at www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Dental and Veterinary Residents) or by calling Member Services.

B. AMBULANCE AND MEDICAL TRANSPORTATION

The Plan covers certain ambulance and medical transportation for medical emergencies and as shown below.

For Network Benefits. Transfers between network hospitals for treatment by network physicians are covered, if initiated by a network physician. Transfers from a hospital or to home or to other facilities are covered, if medical supervision is required en route.

C. BEHAVIORAL HEALTH SERVICES

1. Mental Health Services

The Plan covers services for mental health diagnoses as described in the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM V) (most recent edition) that lead to significant disruption of function in the Covered Person's life.

The Plan also provides coverage for mental health treatment ordered by a Minnesota court under a valid court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The Plan Manager must be given a copy of the court order and the behavioral care evaluation, and the service must be a covered benefit under this Plan, and the service must be provided by a network provider, or other provider as required by law. The Plan will cover the evaluation upon which the court order was based if it was provided by a network provider. The Plan also provides coverage for the initial mental health evaluation of a child, regardless of whether that evaluation leads to a court order for treatment, if the evaluation is ordered by a Minnesota juvenile court.

a. **Outpatient Services.** The Plan covers medically necessary outpatient professional mental health services for evaluation, crisis intervention, and treatment of mental health disorders.

   A comprehensive diagnostic assessment will be made of each patient as the basis for a determination by a mental health professional, concerning the appropriate treatment and the extent of services required.

Outpatient services covered by the Plan for a diagnosed mental health condition include the following:

(1) Individual, group, family, and multi-family therapy;
(2) Medication management provided by a physician, certified nurse practitioner, or physician's assistant;
(3) Psychological testing services for the purposes of determining the differential diagnoses and treatment planning for patients currently receiving behavioral health services;
(4) Day treatment and intensive outpatient services in a licensed program;
(5) Partial hospitalization services in a licensed hospital or community mental health center; and
(6) Psychotherapy and nursing services provided in the home if authorized by HealthPartners.

b. **Inpatient Services.** The Plan covers medically necessary inpatient services in a hospital and professional services for treatment of mental health disorders. Medical stabilization is covered under inpatient hospital services in the "Hospital and Skilled Nursing Facility Services" section.

The Plan covers residential care for the treatment of eating disorders in a licensed facility, as an alternative to inpatient care, when it is medically necessary and your physician obtains authorization from HealthPartners.

The Plan also covers medically necessary psychiatric residential treatment for emotionally handicapped children as diagnosed by a physician. This care must be authorized by HealthPartners and provided by a hospital or residential treatment center licensed by the local state or Health and Human Services Department. The child must be under 18 years of age and an eligible dependent according to the terms of this SB. Services not covered under this benefit include shelter services, correctional services, detention services, transitional services, group residential services, foster care services and wilderness programs.

2. Chemical Health Services

The Plan covers medically necessary services for assessments by a licensed alcohol and drug counselor and treatment of substance-related disorders as defined in the latest edition of the DSM IV.

a. **Outpatient Services including day treatment and intensive outpatient services.** The Plan covers medically necessary outpatient professional services for diagnosis and treatment of chemical dependency. Chemical dependency treatment services must be provided by a program licensed by the local Health and Human Services Department.

Outpatient services covered by the Plan for a diagnosed chemical dependency condition include the following:

(1) Individual, group, family, and multi-family therapy provided in an office setting;
(2) Opiate replacement therapy including methadone and buprenorphine treatment; and
(3) Day treatment and intensive outpatient services in a licensed program.

b. **Inpatient Services.** The Plan covers medically necessary inpatient services in a hospital or primary residential treatment in a licensed chemical health treatment center. Primary residential treatment is an intensive residential treatment program of limited duration, typically 30 days or less.

The Plan covers services provided in a hospital that is licensed by the local state and accredited by Medicare.

Detoxification Services. The Plan covers detoxification services in a hospital or community detoxification facility if it is licensed by the local Health and Human Services Department.

Covered services are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available on-line at www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Dental and Veterinary Residents) or by calling Member Services.

D. CHIROPRACTIC SERVICES

The Plan covers chiropractic services for rehabilitative care, rendered to diagnose and treat acute neuromuscular-skeletal conditions.

Massage therapy which is performed in conjunction with other treatment/modalities by a chiropractor and is part of a prescribed treatment plan and is not billed separately is covered.

E. DENTAL SERVICES

1. **Accidental Dental Services.** The Plan covers dentally necessary services to treat and restore damage done to sound, natural, unrestored teeth as a result of an accidental injury. Coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth which result from biting or chewing. When an implant-supported dental prosthetic treatment is pursued, the accidental dental benefit will be applied to the prosthetic procedure. Benefits are limited to the amount that would be paid toward the placement of a removable dental prosthetic appliance that could be used in the absence of implant treatment.

2. **Medical Referral Dental Services.**

   a. **Medically Necessary Outpatient Dental Services.** The Plan covers certain medically necessary outpatient dental services. Coverage is limited to dental services required for treatment of an underlying medical condition, e.g., removal of teeth to complete radiation treatment for cancer of the jaw, cysts and lesions.

   b. **Medically Necessary Hospitalization and Anesthesia for Dental Care.** The Plan covers certain medically necessary hospitalization for dental care. This is limited to charges incurred by a Covered Person who: (1) is a child under age five; (2) is severely disabled; (3) has a medical condition, and requires hospitalization or general anesthesia for dental care treatment; or (4) is a child between age five and 12 and care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful, or when extensive amounts of restorative care, exceeding four appointments, are required. The requirement of a hospital setting must be due to a Covered Person's underlying medical condition. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist professional fees are not covered. The following are examples, though not all-inclusive, of medical conditions which may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Hospitalization required due to the behavior of the Covered Person or due to the extent of the dental procedure is not covered.

   c. **Medical Complications of Dental Care.** The Plan covers certain medical complications of dental care. Treatment must be medically necessary care and related to significant medical complications of non-covered dental care, including complications of the head, neck, or substructures.

3. **Orthognathic Surgery Benefit.** The Plan covers orthognathic surgery for the treatment of severe dysmorphia where a functional occlusion cannot be achieved through non-surgical treatment alone and where a demonstrable functional impairment exists. Functional impairments include but are not limited to significant impairment in chewing, breathing or swallowing. Associated dental or orthodontic services (pre- or post-operatively including surgical rapid palatal expansion) are not covered as a part of this benefit.

4. **Treatment of Cleft Lip and Cleft Palate.** The Plan covers certain treatment of cleft lip and cleft palate of a dependent child, to the limiting age in the definition of an “Eligible Dependent”, including orthodontic treatment and oral surgery directly related to the cleft. Benefits for individuals up to age 26 for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. Dental services which are not necessary for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under the Plan is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic

services. Oral appliances are subject to the same copayment, conditions and limitations as durable medical equipment.

5. Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD). The Plan covers surgical and non-surgical treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD), when such care is medically necessary. Dental services which are not required to directly treat TMD or CMD are not covered.

F. DIAGNOSTIC IMAGING SERVICES

The Plan covers diagnostic imaging, when ordered by a provider and provided in a clinic or outpatient hospital facility.

For Network Benefits, non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility.

G. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

The Plan covers certain equipment and services, as described below.

1. Subject to the limitations below, the Plan covers durable medical equipment and orthotic benefits, including certain disposable supplies, enteral feedings, and the following diabetic supplies and equipment: glucose monitors, insulin pumps, syringes, blood and urine test strips and other diabetic supplies as deemed medically appropriate and necessary, for Covered Persons with gestational, Type I or Type II diabetes.

   Diabetic supplies and equipment are limited to certain models and brands.

   The Plan covers special dietary treatment for Phenylketonuria (PKU) and oral amino acid based elemental formula if it meets HealthPartners medical coverage criteria.

   External hearing aids (including osseointegrated or bone anchored) for Covered Persons age 18 or younger who have hearing loss that is not correctable by other covered procedures. Coverage is limited to one hearing aid for each ear every three years.

2. Coverage of durable medical equipment is limited by the following:

   a. Payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary.
   b. For prosthetic benefits, other than hair prostheses (i.e. wigs) for hair loss resulting from alopecia areata and oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary and enables Covered Persons to conduct standard activities of daily living.
   c. The Plan reserves the right to determine if an item will be approved for rental vs. purchase.

3. Items which are not eligible for coverage include, but are not limited to:
   a. Replacement or repair of any covered items, if the items are: (1) damaged or destroyed by misuse, abuse or carelessness; (2) lost; or (3) stolen.
   b. Duplicate or similar items.
   c. Labor and related charges for repair of any covered items which are more than the cost of replacement by a designated vendor.
   d. Sales tax, mailing, delivery charges, service call charges.
   e. Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation.
   f. Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, hearing aids (implantable and external, including osseointegrated or bone anchored), fitting of hearing aids, speech processors, receivers, communication boards, or computer or electronic assisted communication, except as specifically described in this SB. This exclusion does not apply to cochlear implants, which

are covered as described in the medical coverage criteria. These medical policies (medical coverage criteria) are available by calling Member Services, or on-line at www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Dental, and Veterinary Residents).

g. Household equipment which primarily has customary uses other than medical, such as, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds.
h. Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools, whirlpools and saunas.
i. Modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment.
j. Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carriers.
k. Rental equipment while the Covered Person's owned equipment is being repaired, beyond one month rental of medically necessary equipment.
l. Other equipment and supplies, including but not limited to assistive devices, that the Plan determines are not eligible for coverage.

Durable medical equipment and supplies must be obtained from or repaired by designated vendors.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. The coverage policy for diabetic supplies includes information on the required models and brands. These medical policies (medical coverage criteria) are available on-line at www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Dental and Veterinary Residents) or by calling Member Services.

H. EMERGENCY AND URGENT CARE SERVICES

Urgent Care. These are services to treat an unforeseen illness or injury, which are required in order to prevent a serious deterioration in the Covered Person's health, and which cannot be delayed until the next available clinic hours.

Emergency Care. These are services to treat: (1) the sudden, unexpected onset of illness or injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization; or (2) a condition requiring professional health services immediately necessary to preserve life or stabilize health.

When reviewing claims for coverage of emergency services, HealthPartners medical director will take into consideration a reasonable layperson’s belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment.

The Plan **must be** notified within two working days of admission to an out-of-network hospital, or as soon as reasonably possible under the circumstances.

The Plan covers services for emergency care and urgently needed care if the services are otherwise eligible for coverage in this SB.

Emergency Travel Assistance Program. Plan members and their dependents traveling 100 or more miles away from home and outside of their home country, have emergency medical, travel and personal security assistance 24 hours a day, anywhere in the world, through MEDEX, a leading provider of international travel assistance services. From finding an English-speaking doctor to replacing a prescription, MEDEX has the resources and experience to offer rapid coordination and monitoring of medical care while you are abroad. This benefit is not offered by HealthPartners. It is provided by the University of Minnesota through MEDEX. For more information, contact MEDEX by phone at 800-527-0218 (toll-free) or on-line at http://www.medexassist.com.

I. HEALTH EDUCATION

The Plan covers education for preventive services and education for the management of chronic health problems (such as diabetes).

J. HOME HEALTH SERVICES

The Plan covers skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy and other therapeutic services, prenatal and postnatal services, child health supervision services, phototherapy services for newborns, home health aide services and other eligible home health services when rendered in the Covered Person's home, if the Covered Person is homebound (i.e., unable to leave home without considerable effort due to a medical condition). Lack of transportation does not constitute homebound status. For phototherapy services for newborns and high risk pre-natal services, supplies and equipment are included.

The Plan covers total parenteral nutrition/intravenous ("TPN/IV") therapy, equipment, supplies and drugs in connection with IV therapy. IV line care kits are covered under Durable Medical Equipment.

The Plan covers palliative care benefits. Palliative care includes symptom management, education and establishing goals for care. The requirement that the Covered Person is homebound will be waived for a limited number of home visits for palliative care (as shown in the Schedule of Benefits), if you have a life-threatening, non-curable condition which has a prognosis of two years or less. Additional palliative care visits are eligible under the home health services benefit if you are homebound and meet all other requirements defined in this section.

You do not need to be homebound to receive total parenteral nutrition/intravenous ("TPN/IV") therapy.

Home health services are eligible and covered only when they are:

1. medically necessary; and
2. provided as rehabilitative or terminal care; and
3. ordered by a physician, and included in the written home care plan.

Home health services are not provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home. The Plan will not reimburse family members or residents in the Covered Person's home for the above services.

A service shall not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed nurse. Where a service (such as tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person (or self-administered), without the direct supervision of a licensed nurse, the service shall not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of so-called "blended" services (i.e., services which include skilled and non-skilled components) are covered under the Plan.

K. HOME HOSPICE SERVICES

Applicable Definitions:

Part-time. This is up to two hours of service per day; more than two hours per day is considered continuous care.

Continuous Care. This is from two to 12 hours of service per day provided by a registered nurse, licensed practical nurse, or home health aide, during a period of crisis in order to maintain a terminally ill patient at home.

Appropriate Facility. This is a nursing home, hospice residence or other inpatient facility.

Custodial Care Related to Hospice Services. This means providing assistance in the activities of daily living and the care needed by a terminally ill patient which can be provided by a primary caregiver (i.e., family member or friend) who is responsible for the patient's home care.

1. **Home Hospice Program.** The Plan covers the services described below for Covered Persons who are terminally ill patients and accepted as home hospice program participants. Covered Persons must meet the eligibility requirements of the program, and elect to receive services through the home hospice program. The services will be provided in the patient's home, with inpatient care available when medically necessary as described below. Covered Persons who elect to receive hospice services do so in lieu of curative treatment for their terminal illness for the period they are enrolled in the home hospice program.

    a. Eligibility: In order to be eligible to be enrolled in the home hospice program, a Covered Person must: (1) be a terminally ill patient (prognosis of six months or less); (2) have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than treatment attempting to cure the disease or condition); and (3) continue to meet the terminally ill prognosis as determined by HealthPartners medical director or his or her designee over the course of care. A Covered Person may withdraw from the home hospice program at any time.

    b. Eligible Services: Hospice services include the following services provided by Medicare-certified providers, if provided in accordance with an approved hospice treatment plan.
        (1) Home Health Services:
            (a) Part-time care provided in the Covered Person's home by an interdisciplinary hospice team (which may include a physician, nurse, social worker, and spiritual counselor) and medically necessary home health services are covered.
            (b) One or more periods of continuous care in the Covered Person's home or in a setting which provides day care for pain or symptom management, when medically necessary, will be covered.
        (2) Inpatient Services: The Plan covers medically necessary inpatient services.
        (3) Other Services:
            (a) Respite care is covered for care in the Covered Person's home or in an appropriate facility, to give the patient's primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain a terminally ill patient at home.
            (b) Medically necessary medications for pain and symptom management.
            (c) Medically necessary semi-electric hospital beds and other durable medical equipment are covered.
            (d) Medically necessary emergency and non-emergency care are covered.

2. **What Is Not Covered.** The Plan does not cover the following services:
    a. financial or legal counseling services; or
    b. housekeeping or meal services in the patient's home; or
    c. custodial care related to hospice services, whether provided in the home or in a nursing home; or
    d. any service not specifically described as a covered service under this home hospice services section; or
    e. any services provided by a member of the patient's family or resident in the Covered Person's home.

L. HOSPITAL AND SKILLED NURSING FACILITY SERVICES

1. Medical or Surgical Hospital Services

a. **Inpatient Hospital Services.** The Plan covers the following medical or surgical services, for the treatment of acute illness or injury, which require the level of care only provided in an acute care facility. These services must be authorized by a physician.

Inpatient hospital services include: room and board; the use of operating or maternity delivery rooms; intensive care facilities; newborn nursery facilities; general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, prescription drugs or other medications administered during treatment, blood and blood products (unless

replaced) and blood derivatives, and other diagnostic or treatment related hospital services; physician and other professional medical and surgical services provided while in the hospital.

The Plan covers up to 120 hours of services provided by a private duty nurse or personal care assistant who has provided home care services to a ventilator-dependent patient, solely for the purpose of assuring adequate training of the hospital staff to communicate with that patient.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Sponsor.

Services or items for personal convenience, such as television rental, are not covered.

b. **Outpatient Hospital, Ambulatory Care or Surgical Facility Services.** The Plan covers the following medical and surgical services, for diagnosis or treatment of illness or injury on an outpatient basis. These services must be authorized by a physician.

Outpatient services include: use of operating rooms, maternity delivery rooms or other outpatient departments, rooms or facilities; and the following outpatient services: general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, drugs administered during treatment, blood and blood products (unless replaced) and blood derivatives, and other diagnostic or treatment related outpatient services; physician and other professional medical and surgical services rendered while an outpatient.

For Network Benefits, non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility.

To see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see the benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy in the Schedule of Benefits.

2. Skilled Nursing Facility Care.

The Plan covers room and board, daily skilled nursing and related ancillary services for post acute treatment and rehabilitative care of illness or injury, following a hospital confinement.

M. INFERTILITY SERVICES

The Plan covers certain professional services, services for the diagnosis and treatment of infertility, medically necessary tests, facility charges and laboratory work related to covered services.

N. LABORATORY SERVICES

The Plan covers laboratory tests when ordered by a provider and provided in a clinic or outpatient hospital facility.

O. MASTECTOMY RECONSTRUCTION BENEFIT

The Plan covers reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

P. OFFICE VISITS FOR ILLNESS OR INJURY

The Plan covers the following when medically necessary: professional medical and surgical services and related supplies, including biofeedback, of physicians and other health care providers, and blood and blood products (unless replaced) and blood derivatives.

The Plan also covers diagnosis and treatment of illness or injury to the eyes. Where contact or eyeglass lenses are prescribed as medically necessary for the post-operative treatment of cataracts or for the treatment of aphakia or keratoconous, the initial evaluation, lenses and fitting are covered under the Plan. Covered Persons must pay for lens replacement beyond the initial pair.

The Plan also provides coverage for the initial physical evaluation of a child if it is ordered by a Minnesota juvenile court.

Q. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

The Plan covers the following physical therapy, occupational therapy and speech therapy services:

1. Rehabilitative care to correct the effects of illness or injury.
2. Habilitative care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development.

Massage therapy which is performed in conjunction with other treatment/modalities by a physical or occupational therapist and is part of a prescribed treatment plan and is not billed separately is covered.

R. PRESCRIPTION DRUG SERVICES

The Plan covers prescription drugs and medications, which can be self-administered or are administered in a physician's office.

S. PREVENTIVE SERVICES

The Plan covers the following preventive services:

1. Routine health exams and periodic health assessments. A physician or health care provider will counsel Covered Persons as to how often health assessments are needed based on the age, sex and health status of the Covered Person.
2. Child health supervision services, including pediatric preventive services, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months, and appropriate immunizations to age 18.
3. Routine prenatal care and exams to include visit-specific screening tests, education and counseling.
4. Routine postnatal care and exams to include health exams, assessments, education and counseling relating to the period immediately after childbirth.
5. Routine screening procedures for cancer.
6. Routine eye and hearing exams.
7. Professional voluntary family planning services.
8. Adult immunizations.
9. Women’s preventive health services; including mammograms, screenings for cervical cancer; breast pumps; human papillomavirus (HPV) testing; counseling for sexually transmitted infections; and counseling and screening for human immunodeficiency virus (HIV); and FDA approved contraceptive methods, sterilization procedures, education and counseling.

10. Obesity screening and counseling is covered for all ages during a routine preventive care exam. Intensive obesity management to help you lose weight is covered for Covered Persons age 18 or older that have a body mass index of 30 or more. Your primary care physician can coordinate the services.

Covered services are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. These medical policies (medical coverage criteria) are available on-line at www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Dental and Veterinary Residents) or by calling Member Services.

T. SPECIFIED OUT-OF-NETWORK SERVICES

The Plan covers the following services, when a Covered Person elects to receive them from an out-of-network provider, at the same level of coverage the Plan provides when a Covered Person elects to receive the services from a network provider:

1. Voluntary family planning of the conception and bearing of children.
2. The provider visit(s) and test(s) necessary to make a diagnosis of infertility.
3. Testing and treatment of sexually transmitted diseases (other than HIV).
4. Testing for AIDS and other HIV-related conditions.

U. TRANSPLANT SERVICES

Autologous. This is when the source of cells is from the individual's own marrow or stem cells.

Allogeneic. This is when the source of cells is from a related or unrelated donor's marrow or stem cells.

Autologous Bone Marrow Transplant. This is when the bone marrow is harvested from the individual and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is then reinfused (transplanted).

Allogeneic Bone Marrow Transplant. This is when the bone marrow is harvested from a donor and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is reinfused (transplanted).

Autologous/Allogeneic Stem Cell Support. This is a treatment process that includes stem cell harvest from either bone marrow or peripheral blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell reinfusion, and related care. Autologous/allogeneic bone marrow transplantation and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogeneic stem cell support.

Designated Transplant Center. This is any health care provider, group or association of health care providers designated by the Plan to provide services, supplies or drugs for specified transplants for Covered Persons.

Transplant Services. This is transplantation (including retransplants) of the human organs or tissue listed below, including all related post-surgical treatment, follow-up care and drugs and multiple transplants for a related cause. Transplant Services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of FDA approved Ventricular Assist Devices (VAD), functioning as a temporary bridge to heart transplantation.

What is covered. The Plan covers eligible Transplant Services (as defined above) while you are a Covered Person. Transplants that will be considered for coverage are limited to the following:

1. Kidney transplants for end-stage disease.
2. Cornea transplants for end-stage disease.
3. Heart transplants for end-stage disease.
4. Lung transplants or heart/lung transplants for: (a) primary pulmonary hypertension; (b) Eisenmenger's syndrome; (c) end-stage pulmonary fibrosis; (d) alpha 1 antitrypsin disease; (e) cystic fibrosis; and (f) emphysema.
5. Liver transplants for: (a) biliary atresia in children; (b) primary biliary cirrhosis; (c) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy

or post-necrotic cirrhosis; (d) primary sclerosing cholangitis; (e) alcoholic cirrhosis; and (f) hepatocellular carcinoma.

6. Allogeneic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (a) acute myelogenous leukemia; (b) acute lymphocytic leukemia; (c) chronic myelogenous leukemia; (d) severe combined immunodeficiency disease; (e) Wiskott-Aldrich syndrome; (f) aplastic anemia; (g) sickle cell anemia; (h) non-relapsed or relapsed non-Hodgkin's lymphoma; (i) multiple myeloma; and (j) testicular cancer.
7. Autologous bone marrow transplants or peripheral stem cell support associated with high-dose chemotherapy for: (a) acute leukemias; (b) non-Hodgkin's lymphoma; (c) Hodgkin's disease; (d) Burkitt's lymphoma; (e) neuroblastoma; (f) multiple myeloma; (g) chronic myelogenous leukemia; and (h) non-relapsed non-Hodgkin's lymphoma.
8. Pancreas transplants for simultaneous pancreas-kidney transplants for diabetes, pancreas after kidney, living related segmental simultaneous pancreas kidney transplantation and pancreas transplant alone.

To receive Network Benefits, charges for Transplant Services must be incurred at a designated transplant center.

The transplant-related treatment provided, including the expenses incurred for directly related donor services, shall be subject to and in accordance with the provisions, limitations, maximums and other terms of this SB.

Medical and hospital expenses of the donor are covered only when the recipient is a Covered Person and the transplant and directly related donor expenses have been prior authorized for coverage. Treatment of medical complications that may occur to the donor are not covered. Donors are not considered Covered Persons, and are therefore not eligible for the rights afforded to Covered Persons under this SB.

The list of eligible Transplant Services and coverage determinations are based on established medical policies which are subject to periodic review and modification by HealthPartners medical director.

V. WEIGHT LOSS SURGERY OR BARIATRIC SURGERY

Covered services are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available by calling Member Services or on-line at:

Medical Residents and Fellows: http://www.healthpartners.com/uofmgme
Dental and Veterinary Medicine Residents, Fellows and Interns: http://www.healthpartners.com/uofmres

IV. EXCLUSIONS

In addition to any other benefit exclusions, limitations or terms specified in this SB, the Plan will not cover charges incurred for any of the following services, except as specifically described in this SB:

1. Treatment, procedures, services or drugs which are not medically necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the Covered Person, including skills training.
2. Treatment, procedures, or services or drugs which are provided when you are not covered under this Plan.
3. For Network Benefits, treatment, procedures or services which are not provided by a network provider.
4. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical services. The Plan considers vagus nerve stimulator treatment for the treatment of depression and Quantitative Electroencephalogram treatment for the treatment of behavioral health conditions to be investigative and does not cover these services. The Plan considers the following transplants to be investigative and does not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this SB. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
5. Rest and respite services and custodial care. This includes all services, medical equipment and drugs provided for such care.
6. Room and board for halfway houses, extended care facilities, or comparable facilities, and residential treatment services (except for psychiatric residential treatment for emotionally handicapped children, residential care for the treatment of eating disorders and chemical health treatment is a licensed residential primary treatment center as specified in the "Behavioral Health" section).
7. Foster care, adult foster care and any type of family child care provided or arranged by the local state or county.
8. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.
9. Services from non-medically licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.
10. Cosmetic surgery, cosmetic services and treatments primarily for the improvement of the Covered Person's appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for port wine stain removal and reconstructive surgery.
11. Commercial weight loss programs and exercise programs.
12. Dental treatment, procedures or services not listed in this SB.
13. Vocational rehabilitation and recreational or educational therapy.
14. Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations, and adoption studies.
15. Reversal of sterilization; assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI) and/or in-vitro fertilization (IVF), and all charges associated with such procedures; treatment of infertility after reversal of sterilization; artificial insemination when not medically necessary for the treatment of a Covered Person's medically diagnosed infertility; surrogate pregnancy and related obstetric/maternity benefits; sperm, ova or embryo acquisition, retrieval or storage.
16. Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, measurement and adjustment, and hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this SB. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by logging onto www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Dental and Veterinary Residents) or by calling Member Services.
17. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as specified in this SB. This exclusion does not apply to oral amino acid based elemental formula if it meets HealthPartners medical coverage criteria.

18. Charges for sales tax.
19. Services provided by a family member of the Covered Person, or a resident in the Covered Person's home.
20. Religious counseling, marital/relationship counseling and sex therapy rendered in the absence of a significant mental disorder.
21. Private duty nursing services.
22. Services that are rendered to a Covered Person, who also has other primary insurance coverage for those services and who does not provide the Plan the necessary information to pursue coordination of benefits, as required under the Plan.
23. The portion of a billed charge for an otherwise covered service by a provider, which is in excess of the usual and customary charges, or which is either a duplicate charge for a service or charges for a duplicate service.
24. Charges for services (a) for which a charge would not have been made in the absence of insurance or medical plan coverage, or (b) which the Covered Person is not legally obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the Covered Person.
25. Travel and lodging incidental to travel, regardless if it is recommended by a physician and any travel billed by a provider.
26. Health club memberships.
27. Massage therapy for the purpose of a Covered Person's comfort or convenience.
28. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
29. Autopsies.
30. For Network Benefits, charges incurred for transplants, Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) received at facilities which are not designated facilities, or charges incurred for weight loss services provided by a physician who is not a designated physician.
31. Accident related dental services if treatment is (1) provided to teeth which are not sound and natural, (2) to teeth which have been restored, (3) initiated beyond 12 months from the date of the injury, (4) received beyond the initial treatment or restoration, or (5) received beyond 24 months from the date of injury.
32. Nonprescription (over-the-counter) drugs or medications, unless listed on the formulary and prescribed by a physician or legally authorized health care provider under applicable state law, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the Covered Person obtains a prescription for the item.
32. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including ABA, IEIBT, and Lovaas.
33. Charges for elective home births.
34. Professional services associated with substance abuse intervention. A “substance abuse intervention” is a gathering of family and/or friends to encourage a person covered under this SB to seek substance abuse treatment.
35. Court ordered treatment, except as described under “Mental Health Services” and “Office Visits for Illness and Injury” or as otherwise required by law.
36. Services provided through scheduled telephone visits and services provided through E-Visits.
37. Charges provided by naturopathic providers.
38. Care that is not rehabilitative in nature and medically necessary for the diagnosis and/or treatmtne of acute neuromusculoskeletal conditions.
39. Oral surgery including oral surgery to remove wisdom teeth.
40. Medication Therapy Disease Management consultation.

V. DISPUTES AND COMPLAINTS

A. DETERMINATION OF COVERAGE

Eligible services are covered only when medically necessary for the proper treatment of a Covered Person. HealthPartners medical or dental directors, or their designees, make coverage determinations of medical necessity, restrictions on access and appropriateness of treatment; however the Plan Sponsor will make final authorization for Covered Services.

Coverage determinations are based on established medical policies, which are subject to periodic review and modification by HealthPartners medical or dental directors.

If your claim for medical services was denied based on HealthPartners clinical coverage criteria, you or your provider can discuss the decision with a clinician who reviewed the request for coverage. Call Member Services for assistance.

B. COMPLAINTS

The Plan has a complaint procedure to resolve complaints and disputes. Complaints should be made in writing or orally. They may concern the provision of care by network providers, administrative actions, or claims related to the Plan, including breach, meaning or termination. The complaint system seeks to resolve a dispute which arose during the time of your coverage, or application for coverage.

Complaints must be made to:
HealthPartners
Member Services Department
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 952-883-7500 Outside the metro area: 866-270-5434 (toll free)

VI. CONDITIONS

A. RIGHTS OF REIMBURSEMENT AND SUBROGATION

If the Plan Administrator pays medical benefits for medical or dental expenses you incur as a result of any act of a third party for which the third party is or may be liable, and you later obtain full recovery, you are obligated to reimburse the Plan Administrator for the benefits paid in accord with Minnesota statutes 62A.095 and 62A.096, the laws regulated to subrogation rights. "You" means you and your covered spouse/same-sex domestic partner and dependents for purposes of this Section.

The Plan Administrator's right to reimbursement and subrogation is subject to subtraction for actual monies paid to account for the pro rata share of your costs, disbursements and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless the Plan Administrator is separately represented by its own attorney.

If the Plan Administrator is separately represented by an attorney, the Plan Administrator may enter into an agreement with you regarding your costs, disbursements and reasonable attorney fees, and other expenses. If an agreement cannot be reached on such allocation, the matter shall be submitted to binding arbitration.

Nothing herein shall limit the Plan Administrator's right to recovery from another source which may otherwise exist at law. For purposes of this provision, full recovery does not include payments made by the Plan Administrator or for your benefit. You must cooperate with the Plan Administrator in assisting it to protect its legal rights under this provision.

If you make a claim against a third party for damages that include repayment for medical and medically related expenses incurred for your benefit, you must provide timely written notice to the Plan Administrator of the pending or potential claim. The Plan Administrator, at its option, may take such action as may be appropriate and necessary to preserve its rights under this reimbursement and subrogation provision, including the right to intervene in any lawsuit you have commenced with a third party.

Notwithstanding any other law to the contrary, the statute of limitations applicable to the Plan Administrator's rights for reimbursement or subrogation does not commence to run until the notice has been given.

B. COORDINATION OF BENEFITS

This section applies when you have health care coverage under more than one plan, as defined below. If this section applies, you should look at the B. Order of Benefits Rules on the following page to determine which plan determines benefits first. Your benefits under this Plan are not reduced if the Order of Benefits Rules requires this Plan to pay first. Your benefits under this Plan may be reduced if another plan pays first.

1. Definitions

These definitions apply only to this section.

a. "Plan" is any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

i) Group insurance or group-type coverage, whether insured or uninsured; this includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage.

ii) Coverage under a government plan or one required or provided by law.

"Plan" does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). "Plan" does not include Medicare (Title XVIII, United States Code, as amended from time to time) for Medicare benefits paid or payable to any person for whom Medicare is primary. "Plan" does not include any benefits that, by law, are excess to any private or other nongovernmental program.

b. "This Plan" means the part of the Plan that provides health care benefits.

c. "Primary plan/secondary plan" is determined by the Order of Benefits Rules. When this Plan is a primary plan, its benefits are determined before any other plan and without considering the other plan's benefits. When this Plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When you are covered under more than two plans, this Plan may be a primary plan to some plans and may be a secondary plan to other plans.

d. "Allowable expense" means the necessary, reasonable, and customary items of expense for health care, covered at least in part by one or more plans covering the person making the claim. "Allowable expense" does not include an item or expense that exceeds benefits that are limited by statute or this Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

e. "Claim determination period" means a Plan Year. However, it does not include any part of a year the person is not covered under this Plan, or any part of a year before the date this section takes effect.

2. Order of Benefits Rules

a. **General.** When a claim is filed under this Plan and another plan, this Plan is a secondary plan and determines benefits after the other plan, unless:

i) the other plan has rules coordinating its benefits with this Plan's benefits; and

ii) the other plan's rules and this Plan's rules require this Plan to be primary.

b. **Rules.** This Plan determines benefits using the first of the following rules that applies:

i) **Subscriber.** The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.

ii) **Dependent child of parents not divorced.** When this Plan and another plan cover the same child as a dependent of different persons, called "parents":

- the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but
- if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

However, if the other plan does not have this rule for children of married parents/registered same-sex domestic partners, and instead has a rule based on the gender of the parent, and, if as a result the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

iii) Dependent child of divorced parents. If two or more plans cover a dependent child of divorced parents, the plan determines benefits in this order:

- first, the plan of the parent with custody of the child;
- then, the plan that covers the spouse/same-sex domestic partner of the parent with custody of the child;
- finally, the plan that covers the parent not having custody of the child.

However, if the court decree requires one of the parents to be responsible for the health care expenses of the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has that actual knowledge.

iv) **Active/inactive employee.** The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) determines benefits before a plan that covers that person as a laid off or retired employee (or as that employee's dependent). This rule will not apply unless the other plan has the same rule.

v) **Longer/shorter length of coverage.** If none of the above rules determines the order of benefits, the plan that has covered an employee, member, or subscriber longer determines benefits before the plan that has covered that person for the shorter time.

3. Effect on Benefits of This Plan

a. When *Order of Benefits Rules* requires this Plan to be a secondary plan, this part applies. Benefits of this Plan may be reduced.

b. Reduction in this Plan's benefits takes place when the sum of i) and ii) below exceeds those allowable expenses in a claim determination period. In that case, the benefits of the medical portion of this Plan are reduced so that benefits payable under all plans do not exceed allowable expenses. For the prescription drug portion, benefits payable under this Plan are reduced so that benefits do not exceed allowable expenses less any University of Minnesota Residents and Fellows Health Benefit Plan prescription copays. When benefits of this plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of this Plan.

i) the benefits payable for allowable expenses under this Plan, without applying coordination of benefits, and

ii) the benefits payable for allowable expenses under the other plans, without applying coordination of benefits or a similar provision, whether or not claim is made.

c. **Benefit Reserve**. The Secondary Plan shall calculate its savings by subtracting the amount that it paid as a Secondary Plan from the amount it would have paid had it been primary "COB Savings". These COB Savings shall be recorded in the benefit reserve for the Covered Person and shall be used by the Secondary Plan to pay any allowable expenses, not otherwise paid, that are incurred by the Covered Person during the Claim Determination Period. As each claim is submitted, the Secondary Plan must:
(1) determine its obligation, pursuant to the contract;
(2) determine whether a benefit reserve has been recorded for the Covered Person; and
(3) determine whether there are any unpaid allowable expenses during that Claim Determination Period.

If there is a benefit reserve, the Secondary Plan shall use the Covered Person's recorded benefit reserve to pay up to 100% of the total allowable expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each Claim Determination Period. (A Claim Determination Period is based on calendar year).

4. Right to Receive and Release Needed Information

Certain facts are needed to apply these Coordination of Benefits rules. The Plan Administrator has the right to decide which facts are needed. The Plan Administrator may get needed facts from, or give them to, any other organization or person. The Plan Administrator does not need to tell, or get the consent of, any person to do this unless applicable federal or state law prevents disclosures of information without the consent of the patient or patient's representative. Each person claiming benefits under this plan must provide any facts needed to pay the claim.

5. Facility of Payment

A payment made under another plan may include an amount that should have been paid under this Plan. If this happens, the Plan Administrator may pay that amount to the organization that made that payment. That amount will then be considered a benefit paid under this Plan. The Plan Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

6. Right of Recovery

If the Plan Administrator pays more than it should have paid under these Coordination of Benefits rules, it may recover the excess from any of the following:

a. The persons it paid or for whom it has paid

b. Insurance companies

c. Other organizations

The amount paid includes the reasonable cash value of any benefits provided in the form of services.

C. MEDICARE AND THE PLAN

The provisions in this section apply to some, but not all, Covered Persons who are eligible for Medicare. They apply in situations where the federal Medicare Secondary Payer Program allows Medicare to be the primary payer of a Covered Person's medical care claims. Consult your Plan Sponsor to determine whether or not Medicare is primary in your situation.

Medicare is the primary payer for Covered Persons with end stage renal disease, after the 30 month period following the earlier of (1) the month in which the Covered Person begins a regular course of renal dialysis,

or (2) the first of the month in which the Covered Person became entitled to Medicare, if the Covered Person received a kidney transplant without first beginning dialysis. This is regardless of the size of the Employer. Medicare is primary payer for retirees who are age 65 or over. Also, Medicare is a primary payer for Covered Persons under age 65, who are covered by Medicare because of disability (other than end stage renal disease), when (1) the Employer employs fewer than 100 employees and the Covered Person or their spouse or parent has group health plan coverage due to current employment, or (2) the Covered Person or their spouse or parent has coverage not due to current employment, regardless of the number of employees of the Employer.

Medicare is secondary payer for Medicare enrollees who: (1) are active employees and (2) are covered by Medicare because they have reached age 65 when there are 20 or more employees in the group. The Medicare secondary payer rules change from time to time and the most recent rule will be applied.

The benefits under the Plan are not intended to duplicate any benefits to which Covered Persons are, or would be, entitled under Medicare. All sums payable under Medicare for services provided pursuant to the Plan shall be payable to and retained by the Plan Sponsor. Each Covered Person shall complete and submit to the Plan such consents, releases, assignments and other documents as may be requested by the Plan Manager in order to obtain or assure reimbursement under Medicare for which Covered Persons are eligible.

The Plan also reserves the right to reduce benefits for any medical expenses covered under the Plan by the amount of any benefits available for such expenses under Medicare. This will be done before the benefits under the Plan are calculated. Charges for services used to satisfy a Covered Person's Medicare Part B deductible will be applied under the Plan in the order received by the Plan. Two or more charges for services received at the same time will be applied starting with the largest first.

The benefits under the Plan are considered secondary to those under Medicare if the Covered Person has actually enrolled in Medicare Part B.

The provisions of this section will apply to the maximum extent permitted by federal or state law. The Plan will not reduce the benefits due any Covered Person due to that Covered Person's eligibility for Medicare where federal law requires that the Plan determine the benefits for that Covered Person without regard to the benefits available under Medicare.

VII. CLAIMS PROCEDURES

A. PROCEDURES FOR REIMBURSEMENT OF NETWORK SERVICES

When you present your identification card at the time of requesting network services from providers, paperwork and submission of claims relating to services will be handled for you by your provider. You may be asked by your provider to sign a form allowing your provider to submit the claim on your behalf. If you receive an invoice or bill from your provider for services, other than coinsurance, copayments or deductible amounts, simply return the bill or invoice to your provider, noting your enrollment in the Plan. Your provider will then submit the claim under the Plan. Your claim will be processed for payment according to the Plan Sponsor's coverage guidelines.

B. PROCEDURES FOR REIMBURSEMENT OF SERVICES

1. **Claim Forms.** If claim forms are needed, please contact the Plan Manager at 952-883-7500 or 866-270-5434 (toll-free). You must submit claims to the Plan Manager for out-of-network services on the claim form provided. Claim forms must include written proof which documents the date and type of service, provider name and charges, for which a claim is made.

2. **Proof of Loss.** Claims for services must be submitted to the Plan Manager at the address shown below. You must submit an itemized bill, which documents the date and type of service, provider name and charges, for the services incurred. Claims for services must be submitted within 90 days after the date services were first received for the injury or illness upon which the claim is based. Failure to file a claim within this period of time shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within that time. However, such claim must be filed as soon as

reasonably possible and in no event, except in the absence of your legal capacity, later than 15 months from the date services were first received for the injury or illness upon which the claim is based. If the Plan is discontinued or if HPAI ceases to act as the Plan Manager, the deadline for claim submission is 180 days. The Plan Manager may request that additional information be submitted, as needed, to make a claim determination.

Send itemized bills to: Claims Department
HealthPartners, Inc.
P.O. Box 1289
Minneapolis, MN 55440-1289

3. **Time of Payment of Claims.** Benefits will be paid under the Plan within a reasonable time period.

4. **Payment of Claims.** Payment will be made according to the Plan Sponsor's coverage guidelines. All or any portion of any benefits for out-of-network services provided under the Plan on account of hospital, nursing, medical, or surgical services may, at the Plan Manager's option and, unless you request otherwise in writing not later than the time of filing the claim, be paid directly to the out-of-network provider rendering the services.

5. **Physical Examinations and Autopsy.** In the event the Plan Manager or Plan Sponsor requires information from a physical exam or autopsy to properly resolve a claim dispute, the Plan Manager or Plan Sponsor may request this information from you or your legal representative. Failure to submit the required information may result in denial of your claim.

6. **Clerical Error.** If a clerical error or other mistake occurs, that error does not deprive you of coverage for which you are otherwise eligible nor does it give you coverage under the Plan for which you are not eligible. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage. Determination of your coverage will be made at the time the claim is reviewed. It is your responsibility to confirm the accuracy of statements made by the Plan Sponsor or the Plan Manager, in accordance with the terms of this SB and other Plan documents.

C. TIME OF NOTIFICATION TO CLAIMANT OF CLAIMS

The only claims under your Plan that meet the definition of "pre-service", are those that require pre-certification by CareCheck®. For purposes of this claim and appeal process, all other claims, including requests for prior authorization, are considered "post-service" claims.

1. **Pre-Service Claims (pre-certification requests).**

When a request to CareCheck® for pre-certification for a non-urgent service is requested, an initial determination must be made within 15 calendar days. This time period may be extended for an additional 15 calendar days, provided that the Plan Manager determines that such extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 15-day period.

When a request to CareCheck® for pre-certification for an urgent service is requested, an initial determination must be made within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event that the claimant has not provided all information necessary to make a decision, the claimant will be notified of such failure within 24 hours. The claimant will then be given 48 hours to provide the requested information. The claimant will be notified of the benefit determination within 48 hours after the earlier of receipt of the complete information or the end of the time granted to the claimant to provide the specified additional information.

2. **Post-Service Claims.**

An initial determination of a claim for benefits must be made by HealthPartners within 30 days. This time period may be extended for an additional 15 days, provided that the Plan Manager determines that such an extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 30-day period.

You will receive written notification of any initial adverse claim determination as provided by applicable law.

D. CLAIM DENIALS AND CLAIM APPEALS PROCESS FOR PRE-SERVICE CLAIMS

If your request to CareCheck® for pre-certification is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the named fiduciary of your Plan or its delegate. You may also have the right to an external review as described below. You must exhaust the first and second levels of the appeal process prior to bringing a civil action. The steps in this appeal process are outlined below.

1. **First Level of Appeal to the Plan Manager.** You or your authorized representative must file your appeal within 180 days of the adverse decision. Send your written request for review, including comments, documents, records and other information relating to the claim, the reasons you believe you are entitled to benefits, and any supporting documents to:

   Member Services Department
   HealthPartners, Inc.
   8170 33rd Avenue South, P.O. Box 1309
   Minneapolis, MN 55440-1309

   Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

   The Plan Manager will review your appeal and will notify you of its decision in accordance with the following timelines:

   - If the claim being appealed is for urgent services, you may request an expedited appeal either orally or in writing. Within 72 hours of such request, a decision on your appeal will be made.

   - If the claim being appealed is for non-urgent services, a decision on your appeal will be made within 15 days.

   The time periods may be extended if you agree.

   All notifications described above will comply with applicable law.

2. **Second Level of Appeal to the Plan Sponsor.** If after the first level of appeal your request was denied, you or your authorized representative may, within 180 days of the denial, submit a written appeal for review, including any relevant documents, to the Plan Sponsor and submit issues, comments and additional information as appropriate to:

   University of Minnesota
   Office of Student Health Benefits
   410 Church Street SE, Room 323
   Minneapolis, MN 55455

   - If the claim being appealed is for urgent services, you may request an expedited appeal either orally or in writing. Within 72 hours of such request, a decision on your appeal will be made.

   - If the claim being appealed is for non-urgent services, a decision on your appeal will be made within 15 days.

   The time periods may be extended if you agree.

   All notifications described above will comply with applicable law.

3. **External Review Procedures.** For external review procedures, please contact the Plan Sponsor.

E. CLAIM DENIALS AND CLAIM APPEALS PROCESS FOR POST-SERVICE CLAIMS (all claims except requests from CareCheck® for pre-certification)

If your post-service claim for benefits under the Plan is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the named fiduciary of your Plan or its delegate. You may also have the right to an external review as described below. You must exhaust the first and second levels of the appeal process prior to bringing a civil action. The steps in this appeal process are outlined below.

1. **First Level of Appeal to the Plan Manager.** You or your authorized representative must file your appeal within 180 days of the adverse decision. Send your written request for review, including comments, documents, records and other information relating to the claim, the reasons you believe you are entitled to benefits, and any supporting documents to:
   Member Services Department
   HealthPartners, Inc.
   8170 33rd Avenue South, P.O. Box 1309
   Minneapolis, MN 55440-1309

   Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

   The Plan Manager will review your appeal and will notify you of its decision within 30 days. The time period may be extended if you agree.

   All notifications described above will comply with applicable law.

2. **Second Level of Appeal to the Plan Sponsor.** If after the first level of appeal, your request was denied, you or your authorized representative may, within 180 days of the denial, submit a written appeal for review, including any relevant documents, to the Plan Sponsor and submit issues, comments and additional information as appropriate to:

   University of Minnesota
   Office of Student Health Benefits
   410 Church Street SE, Room 323
   Minneapolis, MN 55455

   The Plan Sponsor will review your appeal and will notify you of its decision within 30 days.

   The time periods may be extended if you agree.

   All notifications described above will comply with applicable law.

3. **External Review Procedures.** For external review procedures, please contact the Plan Sponsor.

VIII. EMERGENCY MEDICAL ASSISTANCE PROGRAM

A. PROCEDURES FOR REIMBURSEMENT OF NETWORK SERVICES

When you and your eligible dependents enroll in a University of Minnesota Residents and Fellows Health Benefit Plan medical plan, you are automatically covered as well under the University's Emergency Medical Assistance Program. This program provides worldwide emergency medical assistance — including assistance with emergency evacuations and repatriations — and other travel assistance services when you are 100 or more miles away from home.

FrontierMEDEX Global Solutions administers the Emergency Medical Assistance Program. FrontierMEDEX is available to assist you 24 hours a day, seven days a week, 365 days a year by calling 800-527-0218 (toll-free). When you are receiving medical treatment 100 or more miles from home, or in a foreign country, you are still subject to the usual terms and conditions of your University of Minnesota Residents and Fellows Health Benefit Plan medical plan, as described in this Summary of Benefits, with respect to hospital and medical expenses. You are still responsible for any copayments, coinsurance, or deductibles that are incurred with treatment. FrontierMEDEX will work closely with your Plan Administrator to coordinate the emergency medical assistance services with your University of Minnesota Residents and Fellows Health Benefit Plan.

If you have a medical or travel problem while 100 or more miles from home, call FrontierMEDEX for assistance. Their toll-free and collect-call telephone numbers are printed on your FrontierMEDEX identification card. A multilingual assistance coordinator will ask for your name, your company or group name, the group number shown on your ID card, and a description of your situation. FrontierMEDEX will immediately begin assisting you. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact one of the Assistance Centers. FrontierMEDEX will then take the appropriate action to assist you and monitor your care until the situation is resolved.
The Emergency Medical Assistance Program provides you with Medical Assistance Services, Medical Evacuation and Repatriation Services, and Travel Assistance and Personal Security Services. The document from FrontierMEDEX included with the ID card has a full description of the services available through the program. The services are subject to certain conditions, limitations, and exclusions that are also described in the document.

Medical Assistance Services
- Worldwide medical and dental referrals
- Monitoring of treatment
- Facilitation of hospital payment
- Transfer of insurance information to medical providers
- Medication, vaccine, and blood transfers
- Replacement of corrective lenses and medical devices
- Dispatch of doctors/specialists
- Medical records transfer
- Continuous updates to family, employer, and physician
- Hotel arrangements for convalescence

Worldwide Destination Intelligence
- Pre-Travel information
- Travel and health Information
- Real-time security intelligence
- Emergency medical evacuation
- Transportation to join a hospitalized member
- Return of dependent children
- Transportation after stabilization
- Repatriation of mortal remains

Travel Assistance and Personal Security Services
- Pretravel information
- Emergency travel arrangements
- Transfer of funds and replace lost or stolen travel documents
- Legal referrals
- Translation services and message transmittals
- Emergency pet housing and/or pet return
- Political and security evacuation services
- Transportation after evacuation services

Note: Assistance with arrangements provided, but member is responsible for cost.

Please refer to your program description for full details regarding the benefits, coverages, and limitations of the FrontierMEDEX assistance program. To request additional information on the program or additional cards, contact the Office of Student Health Benefits at 612-624-0627 or 800-232-9017 (toll-free).

Children's Health Insurance Program Notice

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **877-KIDS NOW (toll-free)** or **www.insurekidsnow.gov** to find out how to apply.

If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan — as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in Minnesota, you may be eligible for assistance paying your employer health plan premiums. You should contact your state for further information on eligibility and CHIP.

Website: **http://www.dhs.state.mn.us/**
Click on Health Care, then Medical Assistance

Phone (outside of Twin Cities area): 800-657-3739 (toll-free)
Phone (Twin Cities area): 651-431-2670

Website: **http://www.nyhealth.gov/health_care/medicaid/**
Phone: 800-541-2831 (toll-free)

If you live in another state, contact the Office of Student Health Benefits to obtain more information about the availability of CHIP coverage.

COBRA Notice

This notice contains important information concerning your right to COBRA continuation coverage – a temporary extension of benefit coverage under the University of Minnesota Residents and Fellows Health Benefit Plan that can become available to you and other eligible members of your family in the event you later lose group coverage through the plan. The right to COBRA continuation was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Under the University of Minnesota Residents and Fellows Health Benefit Plan, COBRA coverage applies to medical and dental benefits and the flexible spending account. Minnesota state law continuation applies to life insurance benefits.

Note: This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

This notice provides a summary of your COBRA continuation rights. For more information about your rights and obligations under the University of Minnesota Residents and Fellows Health Benefit Plan and under federal law, you should review the Eligibility section.

A. Continuation of Coverage

COBRA continuation coverage is a continuation of University of Minnesota Residents and Fellows Health Benefit Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the University of Minnesota Residents and Fellows Health Benefit Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses and dependent children may be qualified beneficiaries. Under COBRA, registered same-sex domestic partners are not considered qualified beneficiaries, however, the University will provide continuation benefits to registered same-sex domestic partners on the same terms and conditions as if they were qualified beneficiaries under COBRA. The term qualified beneficiary when used in the University's COBRA continuation materials will therefore be deemed to apply to registered same-sex domestic partners. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage.

1. If you are an employee, you will become a qualified beneficiary if you will lose coverage under the University of Minnesota Residents and Fellows Health Benefit Plan due to one of the following qualifying events:

    a. your hours of employment are reduced below a 50 to 74 percent time appointment; or
    b. your employment is terminated for any reason other than gross misconduct.

2. If you are the spouse/same-sex domestic partner of an employee, you will become a qualified beneficiary if you will lose your coverage under the University of Minnesota Residents and Fellows Health Benefit Plan because any of the following qualifying events:

    a. employee dies;
    b. employee's hours of employment are reduced;
    c. employee's employment ends for any reason other than his or her gross misconduct;
    d. employee retires at age 65 or over and enrolls in Medicare (Part A, Part B); or
    e. employee divorces or terminates same-sex domestic partnership.

3. Your dependent children will become qualified beneficiaries if they will lose coverage under the University of Minnesota Residents and Fellows Health Benefit Plan because of any of the following qualifying events:

    a. employee dies;
    b. employee's hours of employment are reduced;
    c. employee's employment ends for any reason other than his or her gross misconduct;
    d. employee retires at age 65 or over and enrolls in Medicare (Part A, Part B);
    e. dependent child is no longer eligible for coverage because he or she has reached age 26 or has otherwise lost eligibility for the program; or
    f. employee is divorced or same-sex domestic partnership is terminated.

The University of Minnesota Residents and Fellows Health Benefit Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Office of Student Health Benefits has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, death of the employee, or retirement of an employee age 65 or over and enrollment of same employee in Medicare (Part A, Part B, or both); the employer (department, college, or area) must notify the Office of Student Health Benefits of the qualifying event within 30 days of any of these events. Your coverage will terminate at the end of the month in which a qualifying event has occurred unless you elect COBRA continuation coverage. You have 60 days from the date of loss of coverage to elect COBRA continuation coverage.

Note: For other qualifying events – divorce, termination of a same-sex domestic partnership, or a dependent child losing eligibility for coverage – you must notify the Office of Student Health Benefits within 30 days after the qualifying event occurs. You must either send a letter or email of notification to: Office of Student Health Benefits, 410 Church St SE, N323, Minneapolis, MN 55455 or umshbo@umn.edu; or call the Office of Student Health Benefits at 612-624-0627 or 800-232-9017 (toll-free). The Office of Student Health Benefits will send you the appropriate form to complete. This form must then be completed and sent to Office of Student Health Benefits at the address above, and postmarked within the 30-day time limitation. Your coverage will terminate at the end of the month in which the qualifying event occurs unless you elect COBRA continuation coverage. You have 60 days from the date of loss of coverage to elect COBRA continuation coverage.

Once the Office of Student Health Benefits notifies the University of Minnesota Residents and Fellows Health Benefit Plan COBRA Administrator that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA, coverage will begin on the date the University of Minnesota Residents and Fellows Health Benefit Plan coverage would otherwise have been lost.

B. Qualifying Events Determine Length of Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee the COBRA continuation coverage period continues until coverage would have terminated had this event not occurred.

When the qualifying event is a dependent child losing eligibility, divorce, or termination of same-sex domestic partnership, the COBRA continuation coverage period is 36 months. When the qualifying event is the end of employment or a reduction in the employee's hours of employment, COBRA continuation coverage is available for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

1. Disability extension of the 18-month period of continuation coverage

   If you or anyone in your family who is currently covered under the University of Minnesota Residents and Fellows Health Benefit Plan is determined by the Social Security Administration to be disabled at any time during the first **60 days** of COBRA continuation coverage, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

   You must make sure that the Office of Student Health Benefits is notified of the Social Security Administration's (SSA) determination within **60 days** of the latest of:

   a. the date of the SSA determination,
   b. the date of the qualifying event,
   c. the date of the loss of coverage, or
   d. the date you are informed of your obligation and the procedure to provide this information,

   and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the University of Minnesota Residents and Fellows Health Benefit Plan COBRA Administrator. If you fail to notify the Office of Student Health Benefits in writing and postmarked within the time limit, you will lose your right to extend coverage due to disability. Under this provision, you must also notify the Office of Student Health Benefits within 30 days if the SSA determination is revoked.

2. Second qualifying event extension of the 18-month period of continuation coverage

   If another qualifying event occurs during COBRA continuation coverage, your spouse/same-sex domestic partner and dependent children in your family may be eligible for additional months of COBRA continuation coverage, up to a maximum of 36 months. The second qualifying event must be one that would have caused a loss of coverage if your spouse/same-sex domestic partner and dependent children in your family were not currently receiving COBRA continuation coverage. This extension is available to the spouse/same-sex domestic partner and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), is divorced or has a termination of same-sex domestic partnership. The extension is also available to a dependent child who is no longer eligible under the University of Minnesota Residents and Fellows Health Benefit Plan as a dependent child. In all of these cases, you must make sure that the Office of Student Health Benefits is notified in writing within **60 days** of the second qualifying event. This notice must be sent to the University of Minnesota Residents and Fellows Health Benefit Plan COBRA Administrator. If you fail to notify the Office of Student Health Benefits in writing and postmarked within the time limit, you will lose your right to extend coverage.

C. End of COBRA Continuation Coverage

Your COBRA continuation coverage may be terminated prior to the end of the continuation period for any of the following reasons:

1. University of Minnesota no longer provides group insurance to any of its employees.

2. The premium for your continuation coverage is not paid in a timely fashion.

   Note: You will have 45 days from the date you elect COBRA continuation coverage in which to make your first premium payment to the University of Minnesota Residents and Fellows Health Benefit Plan COBRA Administrator. After the first payment, there is a 30-day grace period for all future payments. For example: All regular COBRA continuation payments are due on the first day of the month. If your payment is due on January 1, your payment must be postmarked within 30 days or January 30. Payments made after the 30-day grace period will be returned to you and all coverage will be cancelled as of the end of the month in which the last regular payment was made.

3. After making your COBRA election, you become covered under another group plan that does not include a pre-existing condition clause that applies to you or eligible dependents.

4. After making your COBRA election, you or your dependents become covered under Medicare (Part A, Part B, or both).

5. A final determination has been made by the Social Security Administration that you are no longer disabled. Termination of coverage is effective in the month that begins more than 30 days after the final determination.

D. Cost of Continuation Coverage

Generally, each qualified beneficiary is required to pay the full premium amount (employer and employee contributions) for the continuation coverage elected. The amount a qualified beneficiary may be required to pay cannot exceed 102% (or, for certain disability coverage, 150%) of the amount similarly situated active employees pay for that coverage. Your election materials will indicate how to determine the premium amount for COBRA continuation coverage.

E. Keep Your Plan Informed of Address Changes

In order to protect the rights of you and your family, you should keep the Office of Student Health Benefits informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices sent by you to Office of Student Health Benefits or to the University of Minnesota Residents and Fellows Health Benefit Plan COBRA Administrator. The Office of Student Health Benefits can be contacted at the information listed below.

F. Questions About Billing

The University of Minnesota Residents and Fellows Health Benefit Plan COBRA Administrator is responsible for administering COBRA continuation coverage. If you have any questions about your billing, you may contact the appropriate University of Minnesota Residents and Fellows Health Benefit Plan COBRA Administrator directly.

1. University of Minnesota Residents and Fellows Health Benefit Plan COBRA Administrator — Medical, Dental and Life Insurance:

   For billing questions about medical or dental benefits or life insurance coverages, the University of Minnesota Residents and Fellows Health Benefit Plan COBRA Administrator is:

   Eide Bailly
   U.S. Bancorp Center
   800 Nicollet Mall, Suite 1350
   Minneapolis, MN 55402-7033
   Phone: 612-253-6633 or 800-300-1672 (toll-free)
   Fax: 612-253-6622 or 1-877-918-3622

2. University of Minnesota Residents and Fellows Health Benefit Plan COBRA Administrator — Flexible Spending Account: For billing questions about the flexible spending account, contact:

   Office of Human Resources
   612-624-8647 or 800-756-2363 (toll-free)

G. Questions About Coverage

If you have questions about your COBRA coverage, you should contact the Office of Student Health Benefits at 612-624-0627, 800-232-9017 (toll-free), or umshbo@umn.edu or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of the Regional and District EBSA Offices are available through the EBSA website at www.dol.gov/ebsa.

Important Notice from the University of Minnesota Residents and Fellows Health Benefit Plan Medical Program for Medical, Dental and Veterinary Medicine Residents, Fellows, and Interns; Disabled; and COBRA Participants and Dependents Concerning Your Prescription Drug Coverage and Medicare

If you or a Covered Dependent has Medicare Part A and/or B (or will be eligible within the next 12 months) you'll want to read this notice about your current Prescription Drug Coverage and Medicare. <u>If not, you can disregard this notice</u>.

NOTE: The Centers for Medicare and Medicaid Services (CMS) regulations require us to send this notification to all individuals with prescription drug coverage who are eligible for Medicare. We're including this information in our Summary of Benefits for University of Minnesota Residents and Fellows Health Benefit Plan because we don't know if you're entitled to Medicare or not. Medicare entitlement includes individuals who qualify for Medicare because of a disability or end-stage renal disease (ESRD), as well as individuals who are over age 65.

This notice has information about your current prescription drug coverage with the University of Minnesota Residents and Fellows Health Benefit Plan Medical Program for medical, dental, and veterinary medicine residents, fellows and interns; disabled; and COBRA participants (and dependents) and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. The five plans in the University of Minnesota Retiree Medical Program for Over 65 Retirees will automatically enroll you in the Medicare prescription drug benefit and will include coverage that is at least as good as the Medicare prescription drug benefit.

2. The University of Minnesota has determined that the prescription drug coverage offered by the University of Minnesota Residents and Fellows Health Benefit Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

If you have a spouse or dependent on a Medicare plan, separate communications will be sent to them regarding their coverage.

Because your existing University of Minnesota Residents and Fellows Health Benefit Plan coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in the Medicare prescription drug program.

If you decide to enroll in a Medicare prescription drug plan and drop your University of Minnesota Residents and Fellows Health Benefit Plan prescription drug coverage, be aware that you cannot get this coverage back.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15 through December 7. When you leave employer/union coverage you may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with your University of Minnesota Residents and Fellows Health Benefit Plan and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least one percent per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two month Special Enrollment Period to join a Medicare drug plan.

Contact the Office of Student Health Benefits by calling 612-624-0627 or 800-232-9017 (toll-free).

NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the University of Minnesota Residents and Fellows Health Benefit Plan changes. You also may request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. When you are approaching age 65, you will also receive information about the University of Minnesota's Retiree Medical Programs for retirees over age 65.

For more information about Medicare prescription drug plans:

- Visit **www.medicare.gov**
- Call your state Health Insurance Assistance Program (see 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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: April 2012
Sender: University of Minnesota Office of Student Health Benefits

Notice of Privacy Practices Effective August 24, 2009

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice describes the practices of this Plan and will apply to you to the extent you participate in the plan. This health plan is an organized health care arrangement and may share protected health information for the treatment, payment and health care operations purposes described in this notice.

1. PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

This notice explains how the Plan uses and discloses your protected health information and the rights that you have with respect to accessing that information and keeping it confidential. "Protected health information" means information that individually identifies you, and relates to payment for your health care, your health or condition, or health care you receive, including demographic information. The Plan creates, receives and maintains eligibility and enrollment information, information about your health care claims paid under the Plan, and other protected health information that is necessary to administer the Plan.

The Plan is required by law to maintain the privacy of your protected health information and to provide this notice to you. This notice explains the Plan's legal duties and privacy practices, and your rights regarding your protected health information. The Plan is committed to protecting the privacy of your protected health information by complying with all applicable federal and state laws.

While this notice is in effect, the Plan must follow the privacy practices described. This notice was most recently edited in December 2011. The Plan reserves the right to change its privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. The Plan reserves the right to make such changes effective for all protected health information that the Plan maintains, including information created or received before the changes were made.

You may request a copy of the Plan's privacy notice at any time. For more information about the Plan's privacy practices, or for additional copies of this notice, please contact the Plan using the information listed at the end of this notice.

2. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe the different ways that the Plan uses and discloses your protected health information. Not every use or disclosure within a category is listed, but all uses and disclosures fall into one of the following categories.

a. **Payment:** The Plan may use and disclose protected health information about you for payment purposes, such as determining your eligibility for Plan benefits, facilitating payment for treatment and health care services you receive, determining benefit responsibility under the Plan, coordinating benefits with other Plans, determining medical necessity, and so on. For example, the Plan may share protected health information with third party administrators hired to provide claims services and other administrative services to the Plan.

b. **Health Care Operations:** The Plan may use and disclose protected health information about you for health care operations. These uses and disclosures are necessary to operate the Plan. For example, the Plan uses and discloses protected health information to conduct quality assessment and improvement activities, and for cost management and business management purposes.

c. **Treatment:** The Plan may use or disclose protected health information for treatment purposes, including helping providers to coordinate your care. Only the minimum amount of information necessary will be disclosed. For example, an emergency care provider may contact the Plan to find out what other providers you use, so that he or she can contact them to get medical records necessary to your care, if you are unable to provide that information.

d. **Sharing of Protected Health Information among the Sponsored Health Programs:** The Plan may disclose your protected health information to the University of Minnesota, which sponsors the Plan, but only to permit

the University to perform Plan administration functions. These disclosures may be made only to the administrative units of the University, primarily the Office of Student Health Benefits, involved in Plan administration, and will be strictly limited to disclosures necessary for Plan administration purposes.

e. **Disclosures to Other Plans:** Without your written authorization, the Plan may not use or disclose your protected health information for any reason except those described in this notice.

f. **Uses and Disclosures You Specifically Authorize:** Without your written authorization, the Plan may not use or disclose your protected health information for any reason except those described in this notice. You may give the Plan written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give the Plan an authorization, you may revoke it in writing at any time. If you revoke your permission, the Plan will stop using or disclosing your protected health information in accordance with that authorization, except to the extent the Plan has already relied on it.

g. **Plan Communications with Individuals Involved in the Treatment and/or Payment of Your Care:** In general, the Plan will communicate directly with you about your claims and other Plan-related matters that involve your protected health information. In some cases, however, it may be appropriate to communicate about these matters with other individuals involved in your health care or payment for that care, such as your family, relatives, or close personal friends (or anyone else, if you choose to designate them).

If you agree, the Plan may disclose to these persons protected health information about you that is directly relevant to their involvement in these matters. The Plan may also make such disclosures to these persons if you are given the opportunity to object to the disclosures and do not do so, or if the Plan reasonably infers from the circumstances that you do not object to disclosure to these persons. The Plan would not need to obtain your written authorization. For example, if you are an employee and are attempting to resolve a claims dispute with the Plan, and you orally inform the Plan that your spouse will be calling the Plan for additional discussion of these issues, the Plan would be permitted to disclose protected health information directly relevant to that dispute to your spouse.

The Plan also may use or disclose your name, location and general condition (or death) to notify, or help to notify, persons involved in your care about your situation. If you are incapacitated or in an emergency, the Plan may disclose your protected health information to persons involved in your care (or payment) if it determines that the disclosure is in your best interest.

h. **Communication about Benefits, Products and Services:** The Plan may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives, or to tell you about health-related products or services (or payment or coverage for such products or services) that may be of interest to you. The Plan may use your protected health information to contact you with information about benefits under the Plan, including certain communications about health plan networks, health plan changes, and value-added health plan-related products or services. The Plan may communicate with you face-to-face regarding any benefits, products or services.

i. **Required by Law:** The Plan may use or disclose your protected health information when required to do so by law. For example, disclosures to the Secretary of Health & Human Services for the purpose of determining the Plan's compliance with federal privacy law.

j. **Disaster Relief:** The Plan may use or disclose your name, location and general condition (or death) to a public or private organization authorized to assist in disaster relief efforts.

k. **Public Health and Safety:** The Plan may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others (but only to someone in a position to help prevent the threat). The Plan may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes. The Plan may disclose your protected health information to appropriate authorities if it reasonably believes that you are a possible victim of abuse, neglect, domestic violence or other crimes.

l. **Lawsuits and Disputes:** The Plan may disclose your protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, in accordance with specified procedural safeguards.

m. **Law Enforcement:** Under circumstances, such as a court order, or court-issued warrant, subpoena or summons, or grand jury subpoena, the Plan may disclose your protected health information to law enforcement officials. The Plan also may disclose limited protected health information to a law enforcement official concerning a suspect, fugitive, material witness, crime victim or missing person. The Plan may disclose protected health information about the victim of a crime (under limited circumstances); about a death the Plan believes may be the result of criminal conduct; to report a crime on the premises of the Plan; or, in an emergency, information relating to a crime not on the premises. If you are an inmate of a correctional institution, the Plan may disclose protected health information to the institution or to law enforcement.

n. **Research:** The Plan may use or disclose protected health information for research purposes, provided that the researcher follows certain procedures to protect your privacy. To the extent it is required by state law, the Plan will obtain your consent for a disclosure for research purposes.

o. **Decedents (Death, Organ/Tissue Donation):** The Plan may disclose the protected health information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization, for certain limited purposes.

p. **Military and National Security:** The Plan may disclose to military authorities the protected health information of armed forces personnel under certain circumstances. The Plan may disclose to authorized federal officials protected health information required for intelligence, counter-intelligence, and other national security activities authorized by law.

q. **Workers' Compensation:** The Plan may disclose protected health information about you for worker's compensation or similar programs established by law to provide benefits for work-related injuries or illness.

r. **De-Identified Data:** The Plan may create a collection of information that can no longer be traced back to you (i.e., does not contain individually identifying information).

3. YOUR RIGHTS

a. **Access:** You have the right to look at or get copies of protected health information maintained by the Plan that may be used to make decisions about your Plan eligibility and benefits, with limited exceptions. The Plan reserves the right to require you to make this request in writing. If you prefer, the Plan will prepare a summary or an explanation of your protected health information for a fee.

To request access and/or a full explanation of the fee structure under this Plan, contact the Office of Student Health Benefits at the number shown at the end of this notice.

The Plan may deny your request in very limited circumstances. If the Plan denies your request, you may be entitled to a review of that denial. You will be told how to obtain a review. The Plan will abide by the outcome of that review.

b. **Amendment:** If you feel that your protected health information is incorrect or incomplete, you have the right to request that the Plan amend it. The Plan reserves the right to require this request be in writing, including a reason to support your request.

To submit a request under this Plan, contact the Office of Student Health Benefits at the number shown at the end of this notice.

The Plan may deny your request if the Plan did not create the information you want amended or for certain other reasons. If the Plan denies your request, the Plan will provide you a written explanation and the process to be followed for any additional action.

c. **Accounting of Disclosures:** You have the right to receive a list of routine and non-routine disclosures the Plan has made of your protected health information. This right does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. Your request for the accounting must be in writing.

To request an accounting under this Plan, contact the Office of Student Health Benefits at the number shown at the end of this notice.

You are entitled to such an accounting for the 6 years prior to your request, though not earlier than April 14, 2003. The Plan will provide you with the date on which it made a disclosure, the name of the person or entity to whom it disclosed your protected health information, a description of the protected health information it disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, the Plan may charge you a reasonable, cost-based fee for responding to these additional requests. You will be notified of the cost involved and be given the opportunity to withdraw or change your request before any costs are incurred. The Plan will notify you if your protected health information is compromised due to a breach. A breach is an inappropriate or unauthorized use or disclosure of protected health information that is not appropriately secured or encrypted.

d. **Restriction Requests:** You have the right to request that the Plan place additional restrictions on its use or disclosure of your protected health information for treatment, payment, or health care operations. The Plan is not required to agree to these restrictions, but if it does, the Plan will abide by its agreement (except in an emergency). Any such agreement by the Plan must be in writing signed by a person authorized to make such an agreement on our behalf; without this written agreement, the Plan will not be bound by the requested restrictions. Please use the contact information at the end of this notice to get more information about how to make such a request.

e. **Confidential Communication:** You have the right to request that the Plan communicate with you about your protected health information by alternative means or to an alternative location. For example, you may ask that the Plan contact you only at work or by mail. You must make your request in writing and must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests for confidential communications. Please use the contact information at the end of this notice for additional information about making such a request.

f. **Copy of this Notice:** You are entitled to receive a printed (paper) copy of this notice at any time. Please contact the plan using the information listed at the end of this notice to obtain a copy of this notice in printed form.

4. QUESTIONS

If you want more information about the Plan's privacy practices, have questions or concerns, or believe that the Plan may have violated your privacy rights, please contact the Plan using the following information:

Office of Student Health Benefits
University of Minnesota
410 Church Street SE, Room N323
Minneapolis, MN 55455
Telephone: 612-624-0627 or 800-232-9017 (toll-free)

You also may submit a written complaint to the U.S. Department of Health and Human Services. The Plan will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

The Plan supports your right to protect the privacy of your medical information. The Plan will not retaliate in any way if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.