Welcome to the 2014–2015

COMPREHENSIVE

STUDENT HEALTH BENEFIT PLAN

Administered by the Office of Student Health Benefits

CROOKSTON CAMPUS
RIGHTS AND RESPONSIBILITIES

You have the right under this plan to:

- be treated with respect, dignity and privacy;
- receive quality health care that is friendly and timely;
- have available and accessible medically necessary covered services, including emergency services, 24 hours a day, seven (7) days a week;
- be informed of your health problems and to receive information regarding treatment alternatives and their risk in order to make an informed choice regardless if the health plan pays for treatment;
- participate with your health care providers in decisions about your treatment;
- give your provider a health care directive or a living will (a list of instructions about health treatments to be carried out in the event of incapacity);
- refuse treatment;
- privacy of medical and financial records maintained by the Plan, the Claims Administrator, and its health care providers in accordance with existing law;
- receive information about the Plan, its services, its providers, and your rights and responsibilities;
- make recommendations regarding these rights and responsibilities policies;
- have a resource at the Plan, the Claims Administrator or at the clinic that you can contact with any concerns about services;
- file an appeal with the Claims Administrator and receive a prompt and fair review; and
- initiate a legal proceeding when experiencing a problem with the Plan or its providers.

You have the responsibility under this plan to:

- know your health plan benefits and requirements;
- provide, to the extent possible, information that the Plan, the Claims Administrator, and its providers need in order to care for you;
- understand your health problems and work with your doctor to set mutually agreed upon treatment goals;
- follow the treatment plan prescribed by your provider or to discuss with your provider why you are unable to follow the treatment plan;
- provide proof of coverage when you receive services and to update the clinic with any personal changes;
- pay copays at the time of service and to promptly pay deductibles, coinsurance, and, if applicable, charges for services that are not covered; and
- keep appointments for care or to give early notice if you need to cancel a scheduled appointment.
Important Notice From the Plan Administrator About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Claims Administrator and about your options under Medicare’s prescription drug coverage. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare 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.

2. The Claims Administrator has determined that the prescription drug coverage offered through your employer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your prescription drug coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. You may keep your current coverage with the Claims Administrator and this Plan will coordinate with your Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your current prescription drug coverage, be aware that you and your dependents might not be able to get this coverage back, depending on your employer’s eligibility policy. This risk might also extend to your medical coverage, so it is worthwhile to ask before enrolling in a Medicare drug plan.

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

You should also know that if you drop or lose your current coverage and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.
If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact Customer Service at the telephone number listed in the Customer Service section.

NOTE: You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan and if coverage under this Plan changes. You may request a copy of this notice anytime.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

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

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

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

This Summary Plan Description ( SPD) contains a summary of the University of Minnesota–Crookston Campus Student Health Benefit Plan (SHBP) and benefits for International Students and Scholars effective August 25, 2014.

Important! When receiving care, always present your identification card to the health care provider who is rendering the services. It is also important that you read this entire Summary Plan Description carefully. It explains the Student Health Benefit Plan, eligibility, notification procedures, covered expenses, and expenses that are not covered. If you have questions about your enrollment, eligibility or benefits at UMC Health Service, please contact the Office of Student Health Benefits at umshbo@umn.edu or 1-800-232-9017.

Coverage under this Student Health Benefit Plan for students and dependents will begin as defined in the “Eligibility” section.

All coverage for dependents and all references to dependents in this Summary Plan Description are inapplicable for student-only coverage.

This Student Health Benefit Plan is financed and administered by the Office of Student Health Benefits on the University of Minnesota–Twin Cities Campus. The Student Health Benefit Plan is a self-funded medical plan. Blue Cross and Blue Shield of Minnesota (Blue Cross) is the Claims Administrator and provides administrative claims payment services only. The Claims Administrator does not assume any financial risk or obligation with respect to claims. Coverage is subject to all terms and conditions of this Summary Plan Description, including medical necessity. The Student Health Benefit Plan Administrator (University of Minnesota, Office of Student Health Benefits) determines eligibility and verifies enrollment.

This Student Health Benefit Plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

This Student Health Benefit Plan is not subject to the Consolidated Omnibus Restoration Act of 1986 (COBRA).

Unless otherwise specifically noted, this Student Health Benefit Plan is not subject to any Federal or State laws that are applicable to employer sponsored group health insurance programs.

To obtain the greatest possible benefits seek care for available services at UMC Health Service first. You may visit any Blue Cross Blue Shield In-Network Provider too.

The Student Health Benefit Plan provides benefits for covered services obtained from eligible health care providers in the Provider Network. In-Network Providers are providers that have entered into a network contract with the Claims Administrator (Blue Cross) to provide you quality health services at favorable prices. Students and Scholars paying the mandatory Student Services Fee receive the highest level of coverage when they use UMC Health Service.

The Student Health Benefit Plan also provides benefits for covered services obtained from Out-of-Network Providers. In some cases, you receive a reduced level of coverage when you use these providers. Out-of-Network Providers include Out-of-Network Participating Providers and Nonparticipating Providers. Out-of-Network Participating Providers have entered into a specific network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan but are not In-Network Providers. Nonparticipating Providers have not entered into a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan. 

You may pay a greater portion of your health care expenses when you use Nonparticipating Providers.

The Student Health Benefit Plan is in full compliance with the Civil Rights Restoration Act of 1987, as this law amended Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. This Student Health Benefit Plan provides pregnancy benefits on the same basis as any other temporary disability, including eligible expenses resulting from childbirth, abortion or miscarriage, or complications of pregnancy.
<table>
<thead>
<tr>
<th>Customer Service</th>
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<tbody>
<tr>
<td><strong>Student Health Benefit Plan Administrator</strong></td>
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<tr>
<td>(Enrollment and eligibility verification)</td>
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<tr>
<td>Office of Student Health Benefits</td>
</tr>
<tr>
<td>410 Church Street S.E., Room N323</td>
</tr>
<tr>
<td>612-624-0627 or 1-800-232-9017 (out of area)</td>
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<tr>
<td><a href="http://www.shb.umn.edu">www.shb.umn.edu</a></td>
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<tr>
<td><strong>UMC Health Service</strong></td>
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<td>www1.crk.umn.edu/services/healthservices</td>
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<tr>
<td><strong>Boynton Health Service Dental Clinic</strong></td>
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<tr>
<td><a href="http://www.bhs.umn.edu">www.bhs.umn.edu</a></td>
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<tr>
<td><strong>Blue Cross Blue Shield of Minnesota</strong></td>
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<tr>
<td>(Questions on coverage and claims)</td>
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<tr>
<td>The Claims Administrator’s customer service staff is available to answer your questions about your coverage and direct your calls for prior authorization, preadmission notification, preadmission certification, and emergency admission notification. Customer service staff will provide interpreter services to assist you if needed. This includes spoken language and hearing interpreters.</td>
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<td>Monday through Thursday: 7:00 a.m. - 7:00 p.m. United States Central Time</td>
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<td>Friday: 9:00 a.m. - 4:30 p.m. United States Central Time</td>
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<td>Hours are subject to change without prior notice.</td>
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<td><strong>Customer Service Telephone Number</strong></td>
</tr>
<tr>
<td>Claims Administrator: 651-662-5004 or toll free 1-866-870-0348</td>
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<td><strong>Blue Cross Blue Shield of Minnesota Website</strong></td>
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<td><a href="http://www.bluecrossmn.com/uofm">www.bluecrossmn.com/uofm</a></td>
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<tr>
<td><strong>BlueCard Telephone Number</strong></td>
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<tr>
<td>Toll free 1-800-810-BLUE (2583)</td>
</tr>
<tr>
<td>This number is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.</td>
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<tr>
<td><strong>BlueCard Website</strong></td>
</tr>
<tr>
<td><a href="http://www.bcbs.com">www.bcbs.com</a></td>
</tr>
<tr>
<td>This website is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.</td>
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<tr>
<td><strong>Claims Administrator’s Mailing Address</strong></td>
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<td>Claims review requests, and written inquiries may be mailed to the address below:</td>
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<tr>
<td>Blue Cross and Blue Shield of Minnesota</td>
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<tr>
<td>P.O. Box 64338</td>
</tr>
<tr>
<td>St. Paul, MN 55164</td>
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<tr>
<td>Prior authorization requests should be mailed to the following address:</td>
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<tr>
<td>Blue Cross and Blue Shield of Minnesota</td>
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<tr>
<td>Utilization Management Department</td>
</tr>
<tr>
<td>P.O. Box 64265</td>
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<tr>
<td>St. Paul, MN 55164</td>
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<td>Service</td>
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<tr>
<td>Pharmacy Telephone Number</td>
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<tr>
<td>Healthy Start® Prenatal Support Telephone Number</td>
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<tr>
<td>Stop-Smoking Support</td>
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<tr>
<td>Travel Assistance, Medical Evacuation &amp; Repatriation</td>
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Healthy Start Prenatal Support

Healthy Start® Prenatal Support is an education and support program for pregnant women. The program helps moms-to-be learn what they need to know to have the healthiest pregnancy and baby possible. Pregnant women complete a health pregnancy assessment to determine their risk level. If you are high risk you will be assigned to a maternity nurse, who will answer your questions, provide education, support, and advocacy during your pregnancy. If your pregnancy is not high risk, you can access the online tools and resources that can be found on the program website. If your condition changes, please call the program to be re-assessed.

The following options are available to request further information or to enroll:

- Call (651) 662-1818, or toll-free 1-866-489-6948
- Email Healthy_Start@bluecrossmn.com
- Visit the Healthy Start Prenatal Support website at www.myhealthystart.org.

Stop-Smoking Support

Stop-Smoking Support is a telephone-based service designed to help you quit using tobacco your way and at your pace. To participate, call the support line at 1-888-662-BLUE (2583) or enroll at mybluecrossmn.com, the Claims Administrator’s website. A Quit Coach will work with you one-on-one to develop a personalized quitting plan that addresses your specific concerns. You will receive written materials and personalized help for up to 12 months.

Care Management

If you or an eligible family member has an ongoing condition like diabetes or heart disease – or you experience a major health event or illness—you may receive an invitation to take advantage of Care Management programs. These programs are voluntary and confidential. A health professional will look beyond your condition and at you as a whole person, matching telephone-based support and educational resources to your needs. A Dedicated Clinician gets to know you over time so you do not have to explain your situation every time you call.

If you think you are eligible to participate in the program and have not been invited, you may call the Customer Service telephone number listed on the back of your card. Once enrolled, you may choose not to participate at any time by calling the Customer Service telephone number listed on the back of your card.

Online Health Assessment and Online Health Coaching Programs

The Online Health Assessment and Online Health Coaching Programs are available to you at myBlueCross, the member center at the Claims Administrator’s website. Taking the Online Health Assessment is your first step to a healthier lifestyle. Answer questions about your health history, nutrition, physical activity, and more. You will instantly get a report just for you. It takes just 20 minutes and is completely confidential. Then take advantage of the Online Health Coaching Programs focused on fitness, nutrition, weight loss, reducing stress, and more. Each program includes an action plan and tips for success to keep you on track.
ELIGIBILITY FOR DOMESTIC STUDENTS

The Student Health Benefit Plan is available to students admitted in a degree program who pay the mandatory Student Services Fee and who are enrolled for six or more eligible credits* (three or more eligible credits during summer term).

*Eligible credits are credits registered for that contribute towards the total count under the enrollment guidelines for being assessed the mandatory Student Services Fee and also require proof of health plan coverage or result in a charge for the Student Health Benefit Plan during the registration process.

Students enrolled for less than six credits (three credits in summer term) are not eligible for participation in the Student Health Benefit Plan. Please contact the Office of Student Health Benefits with questions about eligibility for the Student Health Benefit Plan.

Health Plan Requirement, Enrollment, and Waiver Process

All degree seeking students registered for six (6) or more eligible credits per semester (three (3) or more eligible credits during summer term) are required by the University of Minnesota to have health plan coverage. At registration, students registering for six or more eligible credits will be automatically enrolled in the Student Health Benefit Plan unless they follow established guidelines to obtain a waiver. This information is subject to audit. If information provided during registration is found to be unverifiable, the student will be in violation of the University Student Code of Conduct and charged the nonrefundable fee for the Student Health Benefit Plan.

If students waive the Student Health Benefit Plan, they cannot request enrollment on the Student Health Benefit Plan without providing proof of involuntary discontinuation of coverage from a group plan within 31 days from the date of termination. If the Student Health Benefit Plan Administrator receives the application more than 31 days after the involuntary loss of coverage, the application will be rejected and you must reapply for coverage during the next open enrollment period (the first 31 days of coverage during the subsequent Fall Semester).

Graduate Students Registering for 0999 Credits or Working on Thesis or Plan B Paper may continue coverage after completion of coursework for up to one (1) year. The students must have been enrolled on the plan while taking six (6) eligible class credits the previous semester. To continue coverage the students must be registered for 0999 and submit an enrollment form and letter from the Director of Graduate studies (every semester) verifying that they are making satisfactory progress. Documentation must be received by the enrollment deadline. Students cannot re-enroll if coverage is interrupted.

Students registering for clinical rotations or a clinical internship may continue coverage for the term of their rotations or internship. The students must have been enrolled on the plan while taking six (6) eligible class credits the previous semester. To continue coverage the students must request the Student Services Fee through One Stop, and submit an enrollment form and letter from their department (every semester) listing the dates of their rotations/internship and verifying that they are making satisfactory progress. Documentation must be received by the enrollment deadline. Students cannot re-enroll if coverage is interrupted.

Students who are in their final semester and are expected to graduate at the end of the term but are not meeting eligibility as outlined above may continue coverage for their final semester. Enrolled credits in their final semester must be required for their degree. The students must have been enrolled on the plan while taking six (6) eligible class credits the previous semester. To continue coverage the students must request the Student Services Fee through One Stop, and submit an enrollment form and letter from their department verifying that they are making satisfactory progress and are expected to graduate at the end of the term. Documentation must be received by the enrollment deadline. Students cannot re-enroll if coverage is interrupted.

Students participating in a Learning Abroad experience who were enrolled in the Student Health Benefit Plan the previous term will automatically be enrolled in the Student Health Benefit Plan for the term of their Learning Abroad experience unless they submit and are approved for a waiver. Students are only eligible for a waiver if they have become eligible for and enrolled in other comparable health plan coverage. CISI insurance for Education Abroad is not eligible for a waiver. All eligible students must complete the waiver request process by the Twin Cities campus class registration deadline.
Most students participating in a Learning Abroad experience do not pay the Student Services Fee during their term abroad and thus will not have access to Student Services Fee benefits at Student Health Services. For more information on Student Services Fee benefits at Student Health Services visit www1.crk.umn.edu/services/healthservices/eligibility/index.html. Regular international student waiver guidelines apply.

Learning Abroad students are eligible to enroll in the Student Health Benefit Plan provided they met eligibility requirements the previous semester. Students enrolling in the Student Health Benefit Plan coverage, who were not enrolled the previous semester, must contact the Office of Student Health Benefits before the registration deadline to complete an enrollment form and provide a method of payment.

**Enrollment Deadline**

The Student Health Benefit Plan enrollment deadline coincides with the class registration deadlines set by the Office of the Registrar for each semester and for summer session. Please refer to the Class Schedule or the registration website at www.onestop.umn.edu. The enrollment deadline for dependents is the first 31 days for fall semester coverage, or within 31 days from an eligible life event or involuntary loss of coverage.

**Late Enrollees**

Eligible students and their dependents cannot enroll after the published registration and enrollment deadlines. Exceptions will only be made for those who can demonstrate an involuntary discontinuation of coverage from a group plan. The eligible student and dependents must have been dropped from their plan within 31 days from the date of application and payment of the applicable cost of coverage for the Student Health Benefit Plan for the semester or summer session.

Applications must be submitted with certificate of credible coverage or a letter from the previous group plan verifying involuntary discontinuation of coverage and the date coverage ended. Rates will be determined on a prorated basis. (NOTE: Failure to make premium payments to your group plan, or failure to exercise your right to continue coverage, does not constitute involuntary loss of coverage). If the Student Health Benefit Plan Administrator receives the application more than 31 days after the involuntary loss of coverage, the application will be rejected and you must reapply for coverage during the next open enrollment period (the first 31 days of coverage during the subsequent Fall Semester).

**Cancellation of Coverage While Remaining an Eligible Student**

The Student Health Benefit Plan cannot be cancelled after the class registration deadline and coverage will remain in force through that term. To cancel coverage assessed on the fee statement by the registration deadline, the student must follow the established guidelines for requesting a waiver.

The only exception to the above cancellation provision will be for covered students who enter military service or who become eligible for and enroll in the Graduate Assistant Health Plan. In those cases, the Student Health Benefit Plan will be cancelled on a pro-rata basis upon written request to the Office of Student Health Benefits. The request for cancellation must be submitted with a certificate of coverage to the Office of Student Health Benefits for consideration within 31 days of enrollment in the group plan. This provision also applies to any dependent coverage that is in force for the covered student.

**Loss of Coverage Due to Cancellation of Classes**

Cancellation of any or all classes resulting in the loss of eligibility for the Student Health Benefit Plan will result in coverage being cancelled retroactive to the beginning of the semester. Refunds of the cost of the Student Health Benefit Plan follow the University refund schedule as stated in the Class Fee Refund Schedule.
IMPORTANT: Cancellation of Classes and Continuation of Coverage

Students (and their covered dependents) cannot remain covered on the Student Health Benefit Plan if they have cancelled their classes and/or lost eligibility for the plan. The only exception to this policy is if a student obtains a formal medical withdrawal. Students obtaining a medical withdrawal may apply for re-enrollment on the Plan for the semester if covered on the plan the previous term. The provision to continue coverage is available to eligible students one term in an academic career. A Student Health Benefit Plan enrollment form must be filled out and turned into the Office of Student Health Benefits within one week of submission of the request for medical withdrawal to the One Stop office. The enrollment form must be submitted with proof of medical withdrawal and payment. Upon verification of eligibility the Office of Student Health Benefits will notify the student of the outcome of the application request via their University assigned e-mail account.

Loss of Eligibility

Students no longer meeting eligibility resulting in termination of the Student Health Benefit Plan may contact the Office of Student Health Benefits to obtain details regarding eligibility for and enrollment in the University of Minnesota Continuation Options Plan through Blue Cross and Blue Shield of Minnesota. Enrollment form and payment for coverage under the Continuation Options Plan must be received by Blue Cross and Blue Shield of Minnesota within 60 days of termination of coverage under the Student Health Benefit Plan.

Annual Open Enrollment and Dependent Eligibility

Dependent coverage cannot be cancelled after the Enrollment Form has been submitted to the Office of Student Health Benefits and the coverage period for the term has begun. Coverage will remain in force through that term. Dependent enrollment is on a per semester basis and you must complete enrollment materials each semester by the applicable registration deadline in order for dependent coverage to continue.

A covered student may purchase coverage for his or her spouse, registered same-sex domestic partner, and/or dependent children.

Dependents can only be enrolled: 1) at the same time the student initially becomes eligible and is enrolled on the plan, 2) within 31 days of involuntary loss of other coverage, 3) within 31 days of marriage, birth or adoption, 4) during the open enrollment period (the first 31 days of coverage during Fall Semester).

Dependent children, stepchildren, and legal wards must be under the age of 26 years and declared as dependents on the covered student’s federal income tax forms.

Domestic partners must meet eligibility criteria and complete a Declaration of Domestic Partnership available at the Office of Student Health Benefits prior to the effective date of dependent coverage. Dependents must be covered within the same enrollment period that applies to the covered student or within 31 days of becoming eligible. The period of coverage for dependents will be the same as that of the covered student except for special provisions under Continuation of Coverage.

The Continuation of Coverage provision applies to a covered student’s dependents. If coverage ends because the covered student dies or because of the entry of a valid decree of dissolution of marriage, the dependent spouse and/or children may continue coverage under this Student Health Benefit Plan to the end of the paid term. At the end of the term Blue Cross and Blue Shield of Minnesota will mail a certificate of creditable coverage to the insured upon termination of coverage. Upon discontinuation of eligibility to a covered student’s dependents, the dependent spouse and/or children may purchase coverage under the University of Minnesota Continuation Options Plan from the Claims Administrator within 60 days of loss of coverage. Contact the Office of Student Health Benefits for details regarding the Continuation Options Plan.
ELIGIBILITY FOR INTERNATIONAL STUDENTS AND SCHOLARS

Health Plan Coverage Mandate

The University of Minnesota requires all international students, visiting scholars, and their dependents to enroll in the Student Health Benefit Plan (SHBP) unless they are covered by a United States-based employer-sponsored health plan or the Graduate Assistant Health Plan (GAHP) provided by the University of Minnesota. This requirement applies to any student who has a current University-issued I-20 or J Visa document. Visiting scholars must be at the University for more than 30 days to be eligible for coverage.

This mandate ensures that all international students, scholars and their dependents are compliant with their immigration visa requirements and the University mandate for students to have health plan coverage. This mandate also helps support academic success by guaranteeing that students and scholars have access to preventive health care and medical care in the event of illness or injury while they are enrolled at the University.

The insurance requirement described above applies to students, scholars and their dependents with a current University-issued admitting document. Coverage is guaranteed for international students and scholars from the time they arrive at the University of Minnesota and have their documents validated by International Student and Scholar Services through the point of the student’s or scholar’s departure. Coverage continues as long as the student or scholar meets and maintains criteria for international student or scholar eligibility.

Please contact the Office of Student Health Benefits if you have questions about Student Health Benefit Plan eligibility.

Enrollment

International Students registering for classes will automatically be enrolled in the Student Health Benefit Plan and the amount will be charged to their student account. Students with dependents must enroll their dependents by filling out and submitting an enrollment form and copy of the covered student’s I-20 form or J Visa (listing the eligible dependents) with payment to the Office of Student Health Benefits. International students participating in a Learning Abroad experience are required to maintain coverage under the Student Health Benefit Plan.

Visiting Scholars must enroll themselves and their dependents within 31 days of their arrival at the University by filling out and submitting an enrollment form and copy of the visiting scholars J Visa (listing the eligible dependents) with payment to the Office of Student Health Benefits. Visiting scholars must be at the University for more than 30 days to be eligible for coverage.

Dependent Enrollment:

A covered student or scholar must purchase coverage for his or her spouse, and/or dependent children. Dependents must be enrolled when the student or scholar initially is enrolled on the Student Health Benefit Plan or within 31 days of arrival or becoming eligible for the plan. If the Student Health Benefit Plan Administrator does not receive the application when the student or scholar initially is enrolled or more than 31 days after arrival or becoming eligible for the plan, that student or scholar will have to pay premiums retroactive according to the University policy, to the date he or she was required to enroll. Dependent children, stepchildren, and legal wards must be under the age of 26 years and declared as dependents on the covered student’s I-20 form or J Visa. Dependents must be covered within the same enrollment period that applies to the covered student or scholar or within 31 days of becoming eligible. The period of coverage for dependents will be the same as that of the covered student or scholar except for special provisions under Continuation of Coverage.

The Continuation of Coverage provision applies to a covered student’s or scholar’s dependents. If coverage ends because the covered student or scholar dies or because of the entry of a valid decree of dissolution of marriage, the dependent spouse and/or children may continue coverage under this Student Health Benefit Plan to the end of the paid term. Blue Cross and Blue Shield of Minnesota will mail a certificate of creditable coverage to the insured upon termination of coverage.
Newborn Children

A child born to either a male or female Covered Student, Scholar, or covered dependent while this Student Health Benefit Plan is in force will be covered by this Plan from the moment of birth if enrolled within 31 days of the child’s birth (see the Maternity Expense Benefit section). Coverage for newborn children will consist of coverage for sickness or injury, including necessary care or treatment of congenital defects, birth abnormalities including orthodontic and oral surgery treatment involved in the management of cleft lip and cleft palate, or premature birth.

The Covered Student must contact the Office of Student Health Benefits within 31 days of the child’s birth to enroll the child for such coverage to start from the moment of birth. Dependent eligibility expires concurrently with that of the Covered Student, except under special circumstances as described under “Dependent Eligibility and Enrollment.”

Adding spouse and/or stepchildren

1. If the Student Health Benefit Plan Administrator receives the application within 31 days after you become eligible, coverage for your spouse and/or stepchildren starts on the date of marriage.

   Domestic Students:

2. If the Student Health Benefit Plan Administrator receives the application more than 31 days after the date of marriage the application will be rejected and you must reapply for coverage during the next open enrollment period (the first 31 days of coverage during the subsequent Fall Semester).

   International Students and Scholars:

3. If the Student Health Benefit Plan Administrator receives the application more than 31 days after the date of marriage or more than 31 days after the eligible dependent arrives in the United States, you will have to pay premiums retroactive according to the University policy, to the date you were required to enroll.

Adding newborns and children placed for adoption

1. If the Student Health Benefit Plan Administrator receives the application within 31 days of the date of birth, coverage for your newborn child starts on the date of birth.

   If the Student Health Benefit Plan Administrator receives the application within 31 days of the date of placement, coverage for your adopted child starts on the date of placement.

   Domestic Students:

2. If the Student Health Benefit Plan Administrator receives the application more than 31 days after the date of birth, the application will be rejected and you must reapply for coverage for your newborn child during the next open enrollment period (the first 31 days of coverage during the subsequent Fall Semester).

   If the Student Health Benefit Plan Administrator receives the application more than 31 days after the date of placement, the application will be rejected and you must reapply for coverage for your adopted child during the next open enrollment period (the first 31 days of coverage during the subsequent Fall Semester).

   International Students and Scholars:

3. If the Student Health Benefit Plan Administrator receives the application more than 31 days after the date of birth, you will have to pay premiums retroactive according to the University policy, to the date you were required to enroll.

   If the Student Health Benefit Plan Administrator receives the application more than 31 days after the date of placement, you will have to pay premiums retroactive to the date you were required to enroll according to the University policy.
Adding disabled children or disabled dependents

A disabled dependent may be added to the Student Health Benefit Plan if the disabled dependent is otherwise eligible under the Plan. Coverage starts the first of the month following the day the Student Health Benefit Plan Administrator receives the application. A disabled dependent will not be denied coverage and will not be subject to any preexisting condition limitation period.

1. If the Student Health Benefit Plan Administrator receives the application within 31 days of the date of eligibility, coverage for your disabled dependent starts on the date of eligibility.

   Domestic Students:

2. If the Student Health Benefit Plan Administrator receives the application more than 31 days after the date of eligibility, the application will be rejected and you must reapply for coverage for your disabled dependent during the next open enrollment period (the first 31 days of coverage during the subsequent Fall Semester).

   International Students and Scholars:

3. If the Student Health Benefit Plan Administrator receives the application more than 31 days after the date of eligibility, you will have to pay premiums retroactive according to the University policy, to the date you were required to enroll.

Office of Student Health Benefits Review Process for Eligibility, Enrollment, or Other Administrative Issues

If you are disputing a determination concerning an eligibility, enrollment, or other administrative issue, you may also contact the Office of Student Health Benefits (OSHB) directly, by telephone (612-624-0627 or 1-800-232-9017), fax (612-626-5183), or by mail to Office of Student Health Benefits, University of Minnesota, 410 Church Street S.E., N323, Minneapolis, MN 55455. You must contact the Office of Student Health Benefits within 90 days of the date that the eligibility, enrollment, or other administrative issue first became apparent.

The OSHB representative will first assist you in trying to resolve the concern on an informal basis. If you are unable to resolve your concern informally, a written request for review, including the concerns you have about your eligibility, enrollment, or other administrative issue, plus supporting documentation, can be submitted. You will receive a telephone or written response from the OSHB as soon as possible, but not later than 30 days following the University's receipt of your request for review.

Office of Student Health Benefits Committee Review of Coverage Denials

If your written request for review of your eligibility, enrollment, or other administrative issue is wholly or partially denied, or if you do not agree with the response from the University of Minnesota, Office of Student Health Benefits, you may request a review by the Office of Student Health Benefits Review Committee.

Your request must be in writing and be received by fax (612-626-5183) or by mail at Office of Student Health Benefits, University of Minnesota, 410 Church Street S.E., N323, Minneapolis, MN, 55455, within 60 days of the denial of your written request for review. A written decision will be sent to you from the Office of Student Health Benefits Review Committee within 30 days of the receipt of your request for review.

Office of Student Health Benefits Director Final Review

Within 60 days of receiving a denial of your administrative concern from the Office of Student Health Benefits Review Committee, you may submit a final appeal to the Office of Student Health Benefits Director. You should submit your written request for appeal to Office of Student Health Benefits, University of Minnesota, 410 Church Street S.E., N323, Minneapolis, MN, 55455. The Office of Student Health Benefits Director will render a final written decision regarding your appeal within 45 days of your written request.
STUDENT HEALTH BENEFIT PLAN HIGHLIGHTS

This abbreviated summary is not intended as a substitute for the detailed Student Health Benefit Plan description provided in the balance of this document. Review all details carefully, and if you have any questions, contact the Office of Student Health Benefits at 612-624-0627 or e-mail: umshbo@umn.edu.

Coverage Dates and Costs

<table>
<thead>
<tr>
<th>Semester</th>
<th>Dates of Coverage</th>
<th>Student</th>
<th>Spouse</th>
<th>Child</th>
<th>Children</th>
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</thead>
<tbody>
<tr>
<td>Fall</td>
<td>8/25/2014-1/19/2015</td>
<td>$1,049.00</td>
<td>$1,476.00</td>
<td>$1,086.00</td>
<td>$1,554.00</td>
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<tr>
<td>Spring</td>
<td>1/20/2015-8/21/2015</td>
<td>$1,049.00</td>
<td>$1,476.00</td>
<td>$1,086.00</td>
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<tr>
<td>Monthly—Visiting</td>
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<td>$218.75</td>
<td>$246.00</td>
<td>$181.00</td>
<td>$259.00</td>
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If the husband and wife are both enrolled at the University and are able to satisfy the eligibility requirements for this Student Health Benefit Plan, each may purchase coverage at the student-only cost. Either student may add children who are eligible dependents to their own coverage, but not both.

Summer Coverage

Students covered by the SHBP for the spring semester are automatically covered through the summer at no additional charge, even if they are not enrolled in summer classes.

The following rates are for students and dependents first enrolling in the summer session but who were not covered by the SHBP during the spring semester.

<table>
<thead>
<tr>
<th>Semester</th>
<th>Dates of Coverage</th>
<th>Student</th>
<th>Spouse</th>
<th>Child</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summer</td>
<td>5/18/2015-8/21/2015</td>
<td>$575.00</td>
<td>$777.00</td>
<td>$571.00</td>
<td>$818.00</td>
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</table>

MEDICAL EVACUATION & REPATRIATION BENEFITS

These Benefits are contracted by the Student Health Benefit Plan Administrator with FrontierMEDEX Assistance Corporation. For details, see the enclosed FrontierMEDEX brochure, visit the FrontierMEDEX website at www.medexassist.com or contact FrontierMEDEX Assistance Corporation at 1-800-527-0218. You may also contact the University of Minnesota, Office of Student Health Benefits at 612-624-0627 or e-mail: umshbo@umn.edu.

These Benefits are NOT provided by the Claims Administrator.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

These Benefits are contracted by the Student Health Benefit Plan Administrator. Contact the University of Minnesota Office of Student Health Benefits at 612-624-0627 or e-mail: umshbo@umn.edu for vendor and plan information.

These Benefits are NOT provided by the Claims Administrator.
Choosing A Health Care Provider

You may choose any eligible provider of health services for the care you need. A “provider” is any person, facility, or program that provides covered services which the Claims Administrator determines are within the scope of the provider’s license, certification, registration, or training. The Plan may pay higher benefits if you choose In-Network Providers. Generally you will receive the best benefit from your health plan when you receive care from In-Network Providers.

This Student Health Benefit Plan provides benefits based on the type of health care provider you select when you or your Covered Dependents use health care services. This benefit design has three options. You may use any or all of these options.

If you want to know about the professional qualifications of a specific health care provider, call the provider or clinic directly.

UMC Health Service

Students paying the Student Services Fee receive the highest level of benefit when they use the UMC Health Service. Covered SHBP students who have not paid the Student Services Fee may use the UMC Health Service under the In-Network Provider Benefit level. Note that Student Services Fee benefits can only be obtained in conjunction with active health plan coverage.

The Student Health Benefit Plan may pay higher benefits if you choose In-Network Providers.

The Student Health Benefit Plan features a large network of Participating Providers and each provider is an independent contractor and is not the Claims Administrator’s agent.

In-Network Providers

When you choose these providers, you get the most benefits (other than at UMC Health Service) for the least expense and paperwork. In-Network Providers are providers in the Aware Network and the BlueCard Traditional Network. In-Network Providers send your claims to the Claims Administrator and the Claims Administrator sends payment to the provider for covered services you receive. In-Network Providers may take care of prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification requirements for you (refer to the Notification Requirements section). Your provider directory lists In-Network Providers and may change as providers initiate or terminate their network contracts. For current provider information, call customer service at 651-662-5004 or 1-866-870-0348 or you may access the following website: www.bluecrossmn.com/uofm and click on the Blue Cross (Aware) icon. For benefit information on these providers, refer to the “Benefit Chart.” For benefit information, refer to the Benefit Chart.

Out-of-Network Providers

Out-of-Network Participating Providers

Out-of-Network Participating Providers are providers who have a specific network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan (Participating Providers), but are not In-Network Providers. Out-of-Network Participating Providers may take care of prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification requirements (refer to the Notification Requirements section) and may file claims for you. Verify with your provider if these are services they will provide for you. Most Out-of-Network Participating Providers accept the Claims Administrator’s payment based on the allowed amount. The Claims Administrator recommends that you contact the Out-of-Network Participating Provider and verify if they accept the Claims Administrator’s payment based on the allowed amount to determine if you will have additional financial liability.
Nonparticipating Providers

Nonparticipating Providers have not entered into a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan. You are responsible for providing prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification when necessary and submitting claims for services received from Nonparticipating Providers. Refer to the Liability for Health Care Expenses provision for a description of charges that are your responsibility. Please note that you may incur significantly higher financial liability when you use Nonparticipating Providers compared to the cost of receiving care from In-Network Providers. In addition, participating facilities may have nonparticipating professionals practicing at the facility.

Your Benefits

This SPD outlines the coverage under this Plan. Please be certain to check the Benefit Chart section to identify covered benefits. You must also refer to the General Exclusions section to determine if services are not covered. The Glossary of Common Terms section defines terms used in this SPD. All services must be medically necessary to be covered, and even though certain non-covered services may be medically necessary, there is no coverage for them. If you have questions, call Customer Service using the telephone number on the back of your ID card.

Continuity of Care

Continuity of Care for New Members

If you are a member of a group that is new to the Claims Administrator, this section applies to you. If you are currently receiving care from a family practice or specialty physician who does not participate with the Claims Administrator, you may request to continue to receive care from this physician for a special medical need or condition, for a reasonable period of time before transferring to an In-Network physician as required under the terms of your coverage with this Plan. The Claims Administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician certifies that your life expectancy is 180 days or less. The Claims Administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:

1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable 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 that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or
6. are receiving services from a provider that are delivered in a language other than English.

Continuation through the postpartum period (six (6) weeks post delivery) for a pregnancy beyond the first trimester.
Transition to In-Network Providers

At your request, the Claims Administrator will assist you in making the transition from an Out-of-Network Provider to an In-Network Provider. Please contact the Claims Administrator's customer service staff for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) accept the Claims Administrator’s allowed amount; 2) adhere to all of the Claims Administrator’s prior authorization requirements; and 3) provide the Claims Administrator with necessary medical information related to your care.

Termination by Provider

If your provider terminates its contract with the Claims Administrator, the Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an In-Network Provider must occur on or prior to the date of such termination for you to continue to receive In-Network benefits.

Provider Termination for Cause

If the Claims Administrator has terminated its relationship with your provider for cause, the Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an In-Network Provider must occur on or prior to the date of such termination for you to continue to receive In-Network benefits.

Continuity of Care for Current Members

If you are a current member or dependent, this section applies to you. If the relationship between your In-Network primary care clinic or physician and the Claims Administrator ends, rendering your clinic or provider nonparticipating with the Claims Administrator, and the termination was by the Claims Administrator and not for cause, you may request to continue to receive care for a special medical need or condition, for a reasonable period of time before transferring to an In-Network provider as required under the terms of your coverage with this Plan. The Claims Administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician certifies that your life expectancy is 180 days or less. The Claims Administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:

1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable 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 that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or
6. are receiving services from a provider that are delivered in a language other than English.

Continuation through the postpartum period (six (6) weeks post delivery) for a pregnancy beyond the first trimester.
Transition to In-Network Providers

At your request, the Claims Administrator will assist you in making the transition from an Out-of-Network Provider to an In-Network Provider. Please contact the Claims Administrator’s customer service staff for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) accept the Claims Administrator's allowed amount; 2) adhere to all of the Claims Administrator's prior authorization requirements; and 3) provide the Claims Administrator with necessary medical information related to your care.

Termination by Provider

If your provider terminates its contract with the Claims Administrator, the Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an In-Network Provider must occur on or prior to the date of such termination for you to continue to receive In-Network benefits.

Provider Termination for Cause

If the Claims Administrator has terminated its relationship with your provider for cause, the Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an In-Network Provider must occur on or prior to the date of such termination for you to continue to receive In-Network benefits.

Payments Made in Error

Payments made in error or overpayments may be recovered by the Claims Administrator as provided by law. Payment made for a specific service or erroneous payment shall not make the Claims Administrator or the Plan Administrator liable for further payment for the same service.

Liability for Health Care Expenses

Charges That Are Your Responsibility

For students (with active health plan coverage) paying the Student Services Fee and using UMC Health Service for covered services, you are required to pay the following amounts:

1. charges for services that are not covered.

In-Network Providers

When you use In-Network Providers for covered services, payment is based on the allowed amount. You are not required to pay for charges that exceed the allowed amount. You are required to pay the following amounts:

1. copays and coinsurance;

2. charges that exceed the benefit maximum; and

3. charges for services that are not covered.

Out-of-Network Providers

Out-of-Network Participating Providers

When you use Out-of-Network Participating Providers for covered services, payment is still based on the allowed amount. Most Out-of-Network Participating Providers accept the Claims Administrator’s payment based on the allowed amount.
However, contact your Out-of-Network Participating Provider to verify if they accept the Claims Administrator’s payment based on the allowed amount (to determine if you will have additional financial liability). In addition you are required to pay the following amounts:

1. charges that exceed the allowed amount if the Out-of-Network Participating Provider does not accept the Claims Administrator’s payment based on the allowed amount;

2. copays and coinsurance;

3. charges that exceed the benefit maximum; and

4. charges for services that are not covered.

Nonparticipating Providers

When you use Nonparticipating Providers for covered services, payment is still based on the allowed amount. However, because a Nonparticipating Provider has not entered into a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan, the Nonparticipating Provider is not obligated to accept the allowed amount as payment in full. This means that you may have substantial out-of-pocket expense when you use a Nonparticipating Provider. You are required to pay the following amounts:

1. charges that exceed the allowed amount;

2. copays and coinsurance;

3. charges that exceed the benefit maximum;

4. charges for services that are not covered; including services that we determine are not covered based on claims coding guidelines; and

5. charges for services that are investigative or not medically necessary.

Inter-Plan Programs

Out-of-Area Services

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain health care services outside of the Claims Administrator’s service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Claims Administrator and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the Claims Administrator’s service area, you will obtain care from health care providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from Nonparticipating Providers. The Claims Administrator’s payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered health care services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for fulfilling the Claims Administrator’s contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.
Whenever you access covered health care services outside the Claims Administrator’s service area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:

- the billed covered charges for your covered services; or
- the negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Claims Administrator uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate your liability for any covered health care services according to applicable law.

**Nonparticipating Providers Outside the Claims Administrator’s Service Area**

1. **Member Liability Calculation**

When covered health care services are provided outside of the Claims Administrator’s service area by Nonparticipating Providers, the amount you pay for such services will generally be based on either the Host Blue’s Nonparticipating Provider local payment or the pricing arrangements required by applicable state law. Where the Host Blue’s pricing is greater than the Nonparticipating Provider’s billed charge or if no pricing is provided by a Host Blue, the Claims Administrator generally will pay based on the definition of “Allowed Amount” as set forth in the “Glossary of Common Terms” section of this SPD. In these situations, you may be liable for the difference between the amount that the Nonparticipating Provider bills and the payment the Claims Administrator will make for the covered services as set forth in this paragraph.

2. **Exceptions**

In certain situations, the Claims Administrator may use other payment bases, such as billed covered charges, the payment the Claims Administrator would make if the health care services had been obtained within the Claims Administrator’s service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Claims Administrator will pay for services rendered by Nonparticipating Providers. In these situations, you may be liable for the difference between the amount that the Nonparticipating Provider bills and the payment the Claims Administrator will make for the covered services as set forth in this paragraph.

**General Provider Payment Methods**

**Participating Providers**

The Claims Administrator contracts with a large majority of doctors, hospitals and clinics in Minnesota to be part of its network. Other Blue Cross and Blue Shield Plans contract with providers in their states as well. (Each Blue Cross and/or Blue Shield Plan is an independent licensee of the Blue Cross and Blue Shield Association.) Each provider is an independent contractor and is not an agent or employee of the Claims Administrator, another Blue Cross and/or Blue Shield Plan, or the Blue Cross and Blue Shield Association. These health care providers are referred to as “Participating Providers.” Most Participating Providers have agreed to accept as full payment (less deductibles, coinsurance and copays) an amount that the Claims Administrator has negotiated with its Participating Providers (the “allowed amount”). However, some Participating Providers in a small number of states may not be required to accept the allowed amount as payment in full for your specific plan and will be subject to the Nonparticipating Provider payment calculation noted below.
The Claims Administrator recommends that you verify with your Participating Provider if they accept the allowed amount as payment in full. The allowed amount may vary from one provider to another for the same service.

Several methods are used to pay participating health care providers. If the provider is “participating” they are under contract and the method of payment is part of the contract. Most contracts and payment rates are negotiated or revised on an annual basis.

As an incentive to promote high quality, cost effective care and as a way to recognize that those providers participate in certain quality improvement projects, providers may be paid extra amounts following the initial adjudication of a claim based on the quality of the provider’s care to their patients and further based on claims savings that the provider may generate in the course of rendering cost effective care to its member patients. Certain providers also may be paid in advance of a claim adjudication in recognition of their efficiency in managing the total cost of providing high quality care to members and for implementing quality improvement programs. In order to determine quality of care, certain factors are measured to determine a provider’s compliance with recognized quality criteria and quality improvement. Areas of focus for quality may include, but are not limited to: services for diabetes care; tobacco cessation; colorectal cancer screening; and breast cancer screening, among others. Cost of care is measured using quantifiable criteria to demonstrate that a provider is meeting specific targets to manage claims costs. These quality and cost of care payments to providers are determined on a quarterly or annual basis and will not directly be reflected in a claims payment for services rendered to an individual member. Payments to providers for meeting quality improvement and cost of care goals and for recognizing efficiency are considered claims payments.

- **Non-Institutional or Professional (i.e., doctor visits, office visits) Participating Provider Payments**

  - **Fee-for-Service:** Providers are paid for each service or bundle of services. Payment is based on the amount of the provider’s billed charges.

  - **Discounted Fee-for-Service:** Providers are paid a portion of their billed charges for each service or bundle of services. Payment may be a percentage of the billed charge or it may be based on a fee schedule that is developed using a methodology similar to that used by the federal government to pay providers for Medicare services.

  - **Discounted Fee-for-Service, Withhold and Bonus Payments:** Providers are paid a portion of their billed charges for each service or bundle of services, and a portion (generally 5 - 20 percent) of the provider’s payment is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the provider’s care. In order to determine cost-effectiveness, a per member per month target is established. The target is established by using historical payment information to predict average costs. If the provider’s costs are below this target, providers are eligible for a return of all or a portion of the withhold amount and may also qualify for an additional bonus payment.

Payment for high cost cases and selected preventive and other services may be excluded from the discounted fee-for-service and withhold payment. When payment for these services is excluded, the provider is paid on a discounted fee-for-service basis, but no portion of the provider’s payment is withheld.

- **Institutional (i.e., hospital and other facility) Participating Provider Payments**

  - **Inpatient Care**

    - **Payments for each Case (case rate)** — Providers are paid a fixed amount based upon the member’s diagnosis at the time of admission, regardless of the number of days that the member is hospitalized. This payment amount may be adjusted if the length of stay is unusually long or short in comparison to the average stay for that diagnosis (“outlier payment”). The method is similar to the payment methodology used by the federal government to pay providers for Medicare services.

    - **Payments for each Day (per diem)** — Providers are paid a fixed amount for each day the patient spends in the hospital or facility.

    - **Percentage of Billed Charges** — Providers are paid a percentage of the hospital’s or facility’s billed charges for inpatient or outpatient services, including home services.
- **Outpatient Care**
  - **Payments for each Category of Services** — Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.
  - **Payments for each Visit** — Providers are paid a fixed or bundled amount for all related services a member receives in an outpatient or home setting during one (1) visit.
  - **Payments for each Patient** — Providers are paid a fixed amount per patient per plan year for certain categories of outpatient services.

**Pharmacy Payment**

Four (4) kinds of pricing are compared and the lowest amount of the four (4) is paid:

- the average wholesale price of the drug, less a discount, plus a dispensing fee; or
- the pharmacy’s retail price; or
- the maximum allowable cost we determine by comparing market prices (for generic drugs only); or
- the amount of the pharmacy’s billed charge.

**Nonparticipating Providers**

When you use a Nonparticipating Provider, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A Nonparticipating Provider does not have any agreement with the Claims Administrator or another Blue Cross and/or Blue Shield Plan. For services received from a Nonparticipating Provider (other than those described under “Special Circumstances” below), the allowed amount will be one of the following, to be determined by the Claims Administrator at its discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) based upon a Minnesota nonparticipating provider fee schedule posted at the Claims Administrator’s website; (3) a percentage of billed charges; (4) pricing determined by another Blue Cross or Blue Shield plan; or (5) pricing based upon a nationwide provider reimbursement database. The allowed amount for a Nonparticipating Provider is usually less than the allowed amount for a Participating Provider for the same service and can be significantly less than the Nonparticipating Provider’s billed charges. You will be paid the benefit under the Plan and you are responsible for paying the Nonparticipating Provider. The only exception to this is stated in CLAIMS PROCEDURES, Claims Payment. This amount can be significant and the amount you pay does not apply toward any out-of-pocket maximum contained in the Plan.

In determining the allowed amount for Nonparticipating Providers, the Claims Administrator makes no representations that the allowed amount is a usual, customary or reasonable charge from a provider. See the allowed amount definition for a more complete description of how payments will be calculated for services provided by Nonparticipating Providers.

- **Example of payment for Nonparticipating Providers**

  The following table illustrates the different out-of-pocket costs you may incur using Nonparticipating versus Participating Providers for most services. The example presumes that the member deductible has been satisfied and that the Plan covers 80 percent of the allowed amount for Participating Providers and 60 percent of the allowed amount for Nonparticipating Providers. It also presumes that the allowed amount for a Nonparticipating Provider will be less than for a Participating Provider. The difference in the allowed amount between a Participating Provider and Nonparticipating Provider could be more or less than the 40 percent difference in the following example.

<table>
<thead>
<tr>
<th></th>
<th>Participating Provider</th>
<th>Nonparticipating Provider</th>
</tr>
</thead>
<tbody>
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<td>Provider charge:</td>
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<td>$150</td>
</tr>
<tr>
<td>Allowed amount:</td>
<td>$100</td>
<td>$60</td>
</tr>
<tr>
<td>Claims Administrator pays:</td>
<td>$80 (80 percent of the allowed amount)</td>
<td>$36 (60 percent of the allowed amount)</td>
</tr>
<tr>
<td>Coinurance member owes:</td>
<td>$20 (20 percent of the allowed amount)</td>
<td>$24 (40 percent of the allowed amount)</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Difference up to billed charge member owes:</td>
<td>None (provider has agreed to write this off)</td>
<td>$90 ($150 minus $60)</td>
</tr>
<tr>
<td>Member pays:</td>
<td>$20</td>
<td>$114</td>
</tr>
</tbody>
</table>

The Claims Administrator will, in most cases, pay the benefits for any covered health care services received from a Nonparticipating Provider directly to the member based on the allowed amounts and subject to the other applicable limitations in the Plan. An assignment of benefits from a member to a Nonparticipating Provider generally will not be recognized, except in the instance in which a custodial parent requests, in writing, that the Plan pay a Nonparticipating Provider for covered services for a child.

- **Special Circumstances**

  When you receive care from certain nonparticipating professionals at a participating facility such as a hospital, outpatient facility; or emergency room, the reimbursement to the nonparticipating professional may include some of the costs that you would otherwise be required to pay (e.g., the difference between the allowed amount and the provider’s billed charge).

  This reimbursement applies when nonparticipating professionals are hospital-based and needed to provide immediate medical or surgical care and you do not have the opportunity to select the provider of care. This reimbursement also applies when you receive care in a nonparticipating hospital as a result of a medical emergency.

  - **Example of Special Circumstances**

    Your doctor admits you to the hospital for an elective procedure. Your hospital and surgeon are Participating Providers. You also receive anesthesiology services, but you are not able to select the anesthesiologist. The anesthesiologist is not a Participating Provider. When the claim for anesthesiology services is processed, the Claims Administrator may pay an additional amount because you needed care, but you were not able to choose the provider who would render such services.

Above is a general summary of the Plan’s provider payment methodologies only. Provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary.

Please note that some of these payment methodologies may not apply to your particular plan.

Detailed information about payment allowances for services rendered by Nonparticipating Providers in particular is available at the Claims Administrator’s website.

**Recommendations by Health Care Providers**

Referrals are not required. Your provider may suggest that you receive treatment from a specific provider or receive a specific treatment. Even though your provider may recommend or provide written authorization for a referral or certain services, the provider may be an Out-of-Network Provider or the recommended services may be covered at a lesser level of benefits or be specifically excluded. When these services are referred or recommended, a written authorization from your provider does not override any specific network requirements, notification requirements, or Plan benefits, limitations or exclusions.

**Services that are Investigative or not Medically Necessary**

Services or supplies that are investigative or not medically necessary are not covered. No payment of benefits will be allowed under this Plan including payments for services you have already received. The terms “investigative” and “medically necessary” are defined in the Glossary of Common Terms section.
**Fraudulent Practices**

Coverage for you or your dependents will be terminated if you or your dependent engage in fraud of any type or intentional misrepresentation of material fact including, but not limited to: submitting fraudulent misstatements or omissions about your medical history or eligibility status on the application for coverage; submitting fraudulent, altered, or duplicate billings for personal gain; and/or allowing another party not eligible for coverage under the Plan to use your or your dependent’s coverage.

**Time Periods**

When the time of day is important for benefits or determining when coverage starts and ends, a day begins at 12:00 a.m. United States Central Time and ends at 12:00 a.m. United States Central Time the following day.

**Medical Policy Committee and Medical Policies**

The Claims Administrator’s Medical Policy Committee develops medical policies that determine whether new or existing medical treatment should be covered benefits. The Committee is made up of independent community physicians who represent a variety of medical specialties. The Committee’s goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. The Committee carefully examines the scientific evidence and outcomes for each treatment being considered. The Claims Administrator’s medical policies may be found at the Claims Administrator’s website and are hereby incorporated by reference.
The Claims Administrator reviews services to verify that they are medically necessary and that the treatment provided is the proper level of care. All applicable terms and conditions of your Student Health Benefit Plan including exclusions, deductibles, copays, and coinsurance provisions continue to apply with an approved prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification.

Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required.

**Prior Authorization**

Prior authorization is a process that involves a benefits review and determination of medical necessity before a service is rendered.

For *inpatient hospital/facility services*, In-Network Providers and Out-of-Network Participating Providers are required to obtain prior authorization for you. You are responsible for obtaining prior authorization when receiving *inpatient hospital/facility services* from Nonparticipating Providers.

For *outpatient hospital/facility services or professional services*, Minnesota In-Network Providers are required to obtain prior authorization for you. You are required to obtain prior authorization when you use Out-of-Network Providers in Minnesota and any provider outside Minnesota. However, some of these providers may obtain prior authorization for you. Verify with your providers if this is a service they will perform for you.

If it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges. The Claims Administrator requires that you or the provider contact them at least 10 working days prior to the provider scheduling the care/services to determine if the services are eligible. The Claims Administrator will notify you of their decision within 10 working days, provided that the prior authorization request contains all the information needed to review the service.

The prior authorization list is subject to change due to changes in the Claims Administrator’s medical policy. The Claims Administrator reserves the right to revise, update and/or add to this list at any time without notice. The most current list is available on the Claims Administrator’s website or by calling Customer Service.

The Claims Administrator prefers that all requests for prior authorization be submitted in writing to ensure accuracy. Refer to the Customer Service section for the telephone number and appropriate mailing address for prior authorization requests.

**Preadmission Notification**

Preadmission notification is a process whereby the provider or you inform the Claims Administrator that you will be admitted for inpatient hospitalization services. This notice is required at least five (5) days in advance of being admitted for inpatient care for any type of nonemergency admission and for partial hospitalization.

All In-Network Providers and Out-of-Network Participating Providers are required to provide preadmission notification for you.

If you are going to receive nonemergency care from Nonparticipating Providers, you are required to provide preadmission notification to the Claims Administrator. However, some of these providers may provide preadmission notification for you. Verify with your provider if this is a service they will perform for you. **You are also required to obtain prior authorization for the services related to the inpatient admission. Refer to Prior Authorization in this section. If it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.**

Preadmission notification is required for the following admission/facilities:

1. Hospital acute care admissions;
2. Residential behavioral health treatment facilities; and
3. Mental health and substance abuse admissions.
Penalty Provision

If the Claims Administrator is not notified of your admission a penalty will apply. The Claims Administrator reduces the allowed amount for the admission by 25 percent. This means that without preadmission notification you will pay a greater portion of the charges. The penalty applies when the Claims Administrator is not notified of your admission to Out-of-Network Participating Providers outside Minnesota and Nonparticipating Providers.

To provide preadmission notification, call the customer service telephone number provided in the Customer Service section. They will direct your call.

Preadmission Certification

Preadmission certification is a process to provide a review and determination related to a specific request for care or services. Preadmission certification includes concurrent/length-of-stay review for inpatient admissions. This notice is required in advance of being admitted for inpatient care for any type of nonemergency admission and for partial hospitalization.

All In-Network Providers and Out-of-Network Participating Providers are required to provide preadmission certification for you.

If you are going to receive nonemergency care from Nonparticipating Providers, you are required to provide preadmission certification to the Claims Administrator. However, some of these providers may provide preadmission certification for you. You are also required to obtain prior authorization for the services related to the inpatient admission. Refer to Prior Authorization in this section. If it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.

Preadmission certification is required for the following admissions/facilities:

1. Acute rehabilitation (ACR) admissions;
2. Long-term acute care (LTAC) admissions; and
3. Skilled nursing facilities.

To provide preadmission certification, call the Customer Service telephone number provided in the Customer Service section. They will direct your call.

Emergency Admission Notification

In order to avoid liability for charges that are not considered medically necessary, you are required to provide emergency admission notification to the Claims Administrator as soon as reasonably possible after an admission for pregnancy, medical emergency, or injury that occurred within 48 hours of the admission.

All In-Network Providers and Out-of-Network Participating Providers are required to provide emergency admission notification for you.

If you receive care from Nonparticipating Providers, you are required to provide emergency admission notification to the Claims Administrator. However, some of these providers may provide emergency admission notification for you. Verify with your provider if this is a service they will perform for you. If it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.

To provide emergency admission notification, call the customer service telephone number provided in the Customer Service section. They will direct your call.
CLAIMS PROCEDURES

Under Department of Labor regulations, claimants are entitled to a full and fair review of any claims made under this Student Health Benefit Plan. The claims procedures described in this SPD are intended to comply with those regulations by providing reasonable procedures governing the filing of claims, notification of benefit decisions, and appeals of adverse benefit determinations. A claimant must follow these procedures in order to obtain payment of benefits under this Student Health Benefit Plan. If the Claims Administrator, in its sole discretion, determines that a claimant has not incurred a covered expense or that the benefit is not covered under this Student Health Benefit Plan, no benefits will be payable under this Student Health Benefit Plan. All claims and questions regarding claims should be directed to the Claims Administrator.

Types of Claims

A “claim” is any request for a Student Health Benefit Plan benefit made in accordance with these claims procedures. You become a “claimant” when you make a request for a Student Health Benefit Plan benefit in accordance with these claims procedures. There are four types of claims, each with different claim and appeal rules. The primary difference is the timeframe within which claims and appeals must be determined. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim.

Pre-service Claim

A “Pre-service Claim” is any request for a Student Health Benefit Plan benefit where the Student Health Benefit Plan specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. If the Student Health Benefit Plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no “Pre-service Claim.” The claimant simply follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a Post-service Claim.

Urgent Care Claim

An “Urgent Care Claim” is a special type of Pre-service Claim. An “Urgent Care Claim” is any Pre-service Claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to Pre-service Claims could seriously jeopardize the life or health of the claimant or the claimant’s ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Claims Administrator will determine whether a Pre-service Claim involves urgent care, provided that, if a physician with knowledge of the claimant’s medical condition determines that a claim involves urgent care, the claim will be treated as an Urgent Care Claim.

IMPORTANT: If a claimant needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the Claims Administrator for prior approval. The claimant should obtain such care without delay.

Concurrent Care Claim

A “Concurrent Care Claim” arises when the Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the Claims Administrator determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Claims Administrator has approved. If the Student Health Benefit Plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Claims Administrator to request an extension of a course of treatment. The claimant follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a Post-service Claim.
Post-service Claim

A “Post-service Claim” is any request for a Student Health Benefit Plan benefit that is not a Pre-service Claim or an Urgent Care Claim.

Change in Claim Type

The claim type is determined when the claim is initially filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim may initially be an Urgent Care Claim. If the urgency subsides, it may be re-characterized as a Pre-service Claim. It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding the type of claim and/or what claims procedure to follow, contact the Claims Administrator.

Filing Claims

Except for Urgent Care Claims, discussed below, a claim is made when a claimant (or authorized representative) submits a request for Student Health Benefit Plan benefits to the Claims Administrator. A claimant is not responsible for submitting claims for services received In-Network or Out-of-Network Participating Providers. These providers will submit claims directly to the Claims Administrator on the claimant’s behalf and payment will be made directly to these providers. If a claimant receives services from Nonparticipating Providers, they may have to submit the claims themselves. If the provider does not submit the claims on behalf of the claimant, the claimant should send the claims to the Claims Administrator. The necessary forms may be obtained by contacting the Claims Administrator. A claimant may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that they have incurred a covered expense that is eligible for reimbursement.

Urgent Care Claims

An Urgent Care Claim may be submitted to the Claims Administrator by telephone at 651-662-5004 or toll free 1-866-870-0348.

Pre-service Claims

A Pre-service Claim (including a Concurrent Care Claim that is also a Pre-service Claim) is considered filed when the request for approval of treatment or services is made and received by the Claims Administrator.

Post-service Claims

A Post-service Claim must be filed within 30 days following receipt of the medical service, treatment or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than 12 months after the date of receipt of the service, treatment or product to which the claim relates.

IncorrectlyFiled Claims

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that (a) in the case of an incorrectly-filed Pre-service Claim, the Claims Administrator will notify the claimant as soon as possible but no later than five (5) days following receipt of the incorrectly-filed claim; and (b) in the case of an incorrectly-filed Urgent Care Claim, the Claims Administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incorrectly-filed claim. The notice will explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless the claimant specifically requests written notice.
Timeframes for Deciding Claims

Urgent Care Claims

The Claims Administrator will decide an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Pre-service Claims

The Claims Administrator will decide a Pre-service Claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Concurrent Care Extension Request

If a claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments, the Claims Administrator will decide the claim within 24 hours after receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable timeframes for Pre-service, Urgent Care, or Post-service Claims.

Concurrent Care Reduction or Early Termination

The Claims Administrator’s decision to reduce or terminate an approved course of treatment is an adverse benefit determination that a claimant may appeal under these claims procedures, as explained below. The Claims Administrator will notify the claimant of the decision to reduce or terminate an approved course of treatment sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse benefit determination and receive a decision on appeal before the reduction or termination.

Post-Service Claims

The Claims Administrator will decide a Post-service Claim within a reasonable time, but no later than 30 days after receipt of the claim.

Extensions of Time

A claimant may voluntarily agree to extend the timeframes described above. In addition, if the Claims Administrator is not able to decide a Pre-service or Post-service Claim within the timeframes described above due to matters beyond its control, these timeframes may be extended for up to 15 days, provided the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The notice will describe the matters beyond the Claims Administrator’s control that justify the extension and the date by which the Claims Administrator expects to render a decision. No extension of time is permitted for Urgent Care Claims.

Incomplete Claims

If any information needed to process a claim is missing, the claim will be treated as an incomplete claim. If an Urgent Care Claim is incomplete, the Claims Administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notice will explain that the claim is incomplete, describe the information necessary to complete the claim and specify a reasonable time, no less than 48 hours, within which the claim must be completed. The notice may be oral unless the claimant specifically requests written notice. The Claims Administrator will decide the claim as soon as possible but no later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

If a Pre-service or Post-service Claim is incomplete, the Claims Administrator will notify the claimant as soon as possible. The notice will explain that the claim is incomplete and describe the information needed to complete the claim. The timeframe for deciding the claim will be suspended from the date the claimant receives the notice until the date the necessary information is provided to the Claims Administrator. The Claims Administrator will decide the claim following receipt of the requested information and provide the claimant with written notice of the decision.
Notification of Initial Benefit Decision

The Claims Administrator will provide the claimant with written notice of an adverse benefit determination on a claim. A decision on a claim is an “adverse benefit determination” if it is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a benefit. The Claims Administrator will provide the claimant written notice of the decision on a Pre-service or Urgent Care Claim whether the decision is adverse or not. The Claims Administrator may provide the claimant with oral notice of an adverse benefit determination on an Urgent Care Claim, but written notice will be furnished no later than three (3) days after the oral notice.

Appeals of Adverse Benefit Determinations

Appeal Procedures

A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination. The Claims Administrator will follow these procedures when deciding an appeal:

1. A claimant must file an appeal within 180 days following receipt of a notice of an adverse benefit determination;
2. A claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual;
4. The Claims Administrator will give no deference to the initial benefit decision;
5. The Claims Administrator will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision;
6. The Claims Administrator will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;
7. The Claims Administrator will provide the claimant, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision, even if the Claims Administrator did not rely upon their advice; and
8. The Claims Administrator will provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the Student Health Benefit Plan to the claimant’s medical circumstances; and information regarding any voluntary appeals offered by the Claims Administrator.

Filing Appeals

A claimant must file an appeal within 180 days following receipt of the notice of an adverse benefit determination. A claimant’s failure to comply with this important deadline may cause the claimant to forfeit any right to any further review under these claims procedures or in a court of law. An appeal is filed when a claimant (or authorized representative) submits a written request for review to the Claims Administrator. A claimant is responsible for submitting proof that the claim for benefits is covered and payable under the Student Health Benefit Plan.
Urgent Care Appeals

An urgent care appeal may be submitted to the Claims Administrator by telephone at 651-662-5004 or toll free 1-866-870-0348. The Claims Administrator will transmit all necessary information, including the Claims Administrator’s determination on review, by telephone, fax, or other available similar methods.

Timeframes for Deciding Appeals

Urgent Care Claims

The Claims Administrator will decide the appeal of an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the request for review.

Pre-Service Claims

The Claims Administrator will decide the appeal of a Pre-service Claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt of the written request for review.

Post-service Claims

The Claims Administrator will decide the appeal of a Post-service Claim within a reasonable period, but no later than 60 days after receipt of the written request for review.

Concurrent Care Claims

The Claims Administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. The Claims Administrator will decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for Pre-service, Urgent Care, or Post-service Claims described above, as appropriate to the request.

Notification of Appeal Decision

The Claims Administrator will provide the claimant with written notice of the appeal decision. The Claims Administrator may provide the claimant with oral notice of an adverse decision on an Urgent Care Claim appeal, but written notice will be furnished no later than three (3) days after the oral notice. If the claimant does not receive a written response to the appeal within the timeframes described above, the claimant may assume that the appeal has been denied. The decision by the Claims Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. These claims procedures must be exhausted before any legal action is commenced.

Voluntary Appeals

A voluntary appeal may be available to a claimant receiving an adverse decision on a Pre-service or Post-service Claim appeal. A claimant must file a voluntary appeal within 60 days following receipt of the adverse Pre-service or Post-Service Claim appeal decision. A voluntary appeal is filed when a claimant (or authorized representative) submits a written request for a voluntary appeal to the Claims Administrator. The Claims Administrator will provide the claimant with written notice of voluntary appeal decision. For more information on the voluntary appeals process, contact the Claims Administrator.
**Additional Provisions**

**Authorized Representative**

A claimant may appoint an “authorized representative” to act on his or her behalf with respect to a claim or an appeal of an adverse benefit determination. To appoint an authorized representative, a claimant must complete a form that can be obtained from the Claims Administrator. However, in connection with an Urgent Care Claim, the Claims Administrator will permit a health care professional with knowledge of the claimant’s medical condition to act as the claimant’s authorized representative without completion of this form. Once an authorized representative is appointed, all future communication from the Claims Administrator will be made with the representative rather than the claimant, unless the claimant provides specific written direction otherwise. An assignment for purposes of payment (e.g., to a health care professional) does not constitute an appointment of an authorized representative under these claims procedures. Any reference in these claims procedures to claimant is intended to include the authorized representative of such claimant.

**Office of Student Health Benefits Review Process for Eligibility, Enrollment, or Other Administrative Issues**

If you are disputing a determination concerning an eligibility, enrollment, or other administrative issue, you may also contact the Office of Student Health Benefits (OSHB) directly, by telephone (612-624-0627 or 1-800-232-9017), fax (612-626-5183), or by mail to Office of Student Health Benefits, University of Minnesota, 410 Church Street S.E., N323, Minneapolis, MN 55455. You must contact the Office of Student Health Benefits within 90 days of the date that the eligibility, enrollment, or other administrative issue first became apparent.

The OSHB representative will first assist you in trying to resolve the concern on an informal basis. If you are unable to resolve your concern informally, a written request for review, including the concerns you have about your eligibility, enrollment, or other administrative issue, plus supporting documentation, can be submitted. You will receive a telephone or written response from the OSHB as soon as possible, but not later than 30 days following the University’s receipt of your request for review.

**Office of Student Health Benefits Committee Review of Coverage Denials**

If your pre-authorization of claim under the plan is wholly or partially denied by the Plan Administrator or if you do not agree with the response from the University of Minnesota, Office of Student Health Benefits, you may request a review by the Office of Student Health Benefits Review Committee.

Your request must be in writing and be received by fax (612-626-0808) or by mail at Office of Student Health Benefits, University of Minnesota, 410 Church Street S.E., N323, Minneapolis, MN, 55455, within 60 days of the denial of your coverage. A written decision will be sent to you from the Office of Student Health Benefits Review Committee within 30 days of the receipt of your request for review.

**Office of Student Health Benefits Director Final Review**

Within 60 days of receiving a denial of coverage from the Office of Student Health Benefits Review Committee, you may submit a final appeal to the Office of Student Health Benefits Director. You should submit your written request for appeal to Office of Student Health Benefits, University of Minnesota, 410 Church Street S.E., N323, Minneapolis, MN, 55455. The Office of Student Health Benefits Director will render a final written decision regarding your appeal within 45 days of your written request.

**Claims Payment**

When a claimant uses In-Network or Out-of-Network Participating Providers, the Student Health Benefit Plan pays the provider. When a claimant uses a Nonparticipating Provider the Student Health Benefit Plan pays the claimant. A claimant may not assign his or her benefits to a Nonparticipating Provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the Student Health Benefit Plan pay a Nonparticipating Provider for covered services for a child.
When the Student Health Benefit Plan pays the provider at the request of the custodial parent, the Student Health Benefit Plan has satisfied its payment obligation. This provision may be waived for ambulance providers in Minnesota and certain institutional and medical/surgical providers outside the state of Minnesota at the discretion of the Claims Administrator.

The Student Health Benefit Plan does not pay claims to providers or to employees for services received in countries that are sanctioned by the United States Department of Treasury’s Office of Foreign Assets Control (OFAC), except for medical emergency services when payment of such services is authorized by OFAC. Countries currently sanctioned by OFAC include Cuba, Iran, and Syria. OFAC may add or remove countries from time to time.

**No Third Party Beneficiaries**

The Plan benefits described in this Summary Plan Description are intended solely for the benefit of you and your covered dependents. No person who is not a Plan participant or dependent of a Plan participant may bring a cause of action pursuant to this Summary Plan Description as a third party beneficiary hereof.

**Release of Records**

Claimants agree to allow all health care providers to give the Claims Administrator needed information about the care that they provide to them. The Claims Administrator may need this information to process claims, conduct utilization review and quality improvement activities, and for other health plan activities as permitted by law. If a provider requires special authorization for release of records, claimants agree to provide this authorization. A claimant’s failure to provide authorization or requested information may result in denial of the claimant’s claim.

**Right of Examination**

The Claims Administrator and the Plan Administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The Student Health Benefit Plan pays for the exam whenever either the Claims Administrator or the Plan Administrator requests the exam. A claimant’s failure to comply with this request may result in denial of the claimant’s claim.
This benefit level is only available to covered students who have paid the mandatory Student Services Fee. Covered students and scholars who have not paid the Student Services Fee, may use UMC Health Service under the In-Network benefit level (see the Benefit Chart pages 32-68).

The Student Health Benefit Plan provides 100% coverage for Eligible Expenses incurred at UMC Health Service. These services include the following:

- Acute and emergency health care
- Pregnancy testing
- Referral for HIV/AIDS testing
- Referral for STD testing
- Free Diabetes and Blood Pressure Screenings
- Assistance in referrals and appointments to appropriate health care providers
- Health counseling
- Follow-up care
- Over-the-counter medications and supplies available free of charge
This section lists covered services and the benefits the Student Health Benefit Plan pays. All benefit payments are based on the allowed amount. Coverage is subject to all other terms and conditions of this Summary Plan Description and must be medically necessary.

**Benefit Features, Limitations, and Maximums**

### Networks:
- In-Network Providers

#### Benefit Features

<table>
<thead>
<tr>
<th>Benefit Features</th>
<th>Your Liability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copays</strong></td>
<td></td>
</tr>
<tr>
<td>Retail health clinic copay</td>
<td>$10 per visit</td>
</tr>
</tbody>
</table>

#### Prescription Drugs:

**Retail pharmacy:**
- Generic drug copay: $15 per prescription
- Brand name drug copay: $25 per prescription
- Non-preferred drug copay: 50% per prescription

**90dayRx including participating retail 90dayRx pharmacy and mail service pharmacy:**
- Generic drug copay: $30 per prescription
- Brand name drug copay: $50 per prescription
- Non-preferred drug copay: 50% per prescription

Questions related to Specialty Drug coverage, refer to Boynton Health Service Pharmacy at 612-624-7655.

### Out-of-Pocket Maximums

- All providers combined (except copayments at UMC Health Service incurred by students who have paid the Student Service Fee): $6,250 per person per plan year

Note: Price differences between brand name and generic drugs may be your responsibility in certain instances. This amount is your responsibility and is not credited towards any out-of-pocket maximum.

The following items are applied toward the out-of-pocket maximum:
1. coinsurance;
2. retail health clinic copays; and
3. penalties for not giving the Claims Administrator preadmission notification.

The following item is NOT applied toward the out-of-pocket maximum:
1. prescription drug copays.
**Lifetime Maximum**

- Total benefit paid to all providers combined: Unlimited
  (benefits received at UMC Health Service incurred by students who have paid the Student Services Fee are not charged against the Student Health Benefit Plan maximum)

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**Benefit Descriptions**

Refer to UMC Health Service (page 31) for your highest level of coverage.

Refer to the following pages for a more detailed description of Student Health Benefit Plan benefits.
# Ambulance

<table>
<thead>
<tr>
<th>The Student Health Benefit Plan Covers:</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emergency air or ground transportation licensed to provide basic or advanced life support from the place of departure to the nearest facility equipped to treat the condition</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>• Medically necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse</td>
<td></td>
<td></td>
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</tbody>
</table>

## NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- If the Claims Administrator determines air ambulance was not medically necessary but ground ambulance would have been, the Student Health Benefit Plan pays up to the allowed amount for medically necessary ground ambulance.

## NOT COVERED:

- transportation services that are not medically necessary for basic or advanced life support
- transportation services that are mainly for your convenience (e.g., to a facility other than the nearest facility equipped to treat the condition)
- please refer to the General Exclusions section
### Behavioral Health Mental Health Care

**The Student Health Benefit Plan Covers:**

<table>
<thead>
<tr>
<th></th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient health care</td>
<td>80%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
</tr>
<tr>
<td>professional charges for</td>
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<tr>
<td>services including:</td>
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<tr>
<td>- assessment and diagnostic</td>
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<tr>
<td>services</td>
<td></td>
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<tr>
<td>- individual/group/family</td>
<td></td>
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<tr>
<td>therapy (office/in-home</td>
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<tr>
<td>mental health services)</td>
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<tr>
<td>- neuro-psychological</td>
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<tr>
<td>examinations</td>
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<tr>
<td>Professional health care</td>
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<tr>
<td>charges for services including:</td>
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<tr>
<td>- clinical based partial</td>
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<tr>
<td>programs</td>
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<td></td>
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<tr>
<td>- clinical based day</td>
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<tr>
<td>treatment</td>
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<tr>
<td>- clinical based Intensive</td>
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<tr>
<td>Outpatient Programs (IOP)</td>
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<tr>
<td>Outpatient hospital/outpatient</td>
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<tr>
<td>behavioral health treatment</td>
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<tr>
<td>facility charges for services</td>
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<td>including:</td>
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<tr>
<td>- evaluation and diagnostic</td>
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<tr>
<td>services</td>
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<tr>
<td>- individual/group therapy</td>
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<tr>
<td>- crisis evaluations</td>
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<td>- observation beds</td>
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<tr>
<td>- family therapy</td>
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<tr>
<td>Inpatient health care</td>
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<tr>
<td>professional charges</td>
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<tr>
<td>Inpatient hospital and inpatient</td>
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<tr>
<td>residential behavioral health</td>
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<tr>
<td>treatment facility charges</td>
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<tr>
<td>for services including:</td>
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<tr>
<td>- hospital based partial</td>
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<td>programs</td>
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<td>treatment</td>
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<tr>
<td>- hospital based Intensive</td>
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<tr>
<td>Outpatient Programs (IOP)</td>
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<tr>
<td>- all eligible inpatient</td>
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<tr>
<td>services</td>
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<tr>
<td>- emergency holds</td>
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</table>
NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist is deemed medically necessary.
- Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and otherwise covered under this Student Health Benefit Plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Admissions that qualify as "emergency holds" as the term is defined in Minnesota statutes are considered medically necessary for the entire hold.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, physician time, or psychotherapy.
- Coverage provided for treatment of emotionally disabled children in a licensed residential behavioral health treatment facility is covered the same as any other inpatient hospital medical admission.
- For home health related services, refer to Home Health Care.
- Psychoeducation is covered for individuals diagnosed with schizophrenia, bipolar disorder, and borderline personality disorder. Psychoeducational programs are delivered by an eligible provider to the patient on a group or individual basis as part of a comprehensive treatment program. Patients receive support, information, and management strategies specifically related to their diagnosis.
- Coverage is provided for crisis evaluations delivered by mobile crisis units.

NOT COVERED:

- treatment of attention deficit disorder with or without mention or presence of hyperactivity disorder (testing and evaluation is covered)
- services for mental illness not listed in the most recent edition of the *International Classification of Diseases*
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary; services that are not considered medically necessary include, but are not limited to the following: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency; and domestic violence programs
- room and board for foster care, group homes, incarceration, shelter care, and lodging programs
- halfway house services
- services for marriage/couples counseling
- services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to premarital education; or marriage/couples retreats, encounters, or seminars
- educational services with the exception of nutritional education for individuals diagnosed with anorexia nervosa, bulimia, or eating disorders NOS (not otherwise specified)
- skills training
- therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child’s improved functioning)
- services for or related to intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (IEIBTS); Intensive Behavioral Intervention (IBI); and Lovaas Therapy
- services for the treatment of learning disabilities
- therapeutic day care and therapeutic camp services
- hippotherapy (equine movement therapy)
- please refer to the General Exclusions section
### Behavioral Health Substance Abuse Care

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<th>The Student Health Benefit Plan Covers:</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
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</thead>
<tbody>
<tr>
<td>- Outpatient health care professional charges for services including:</td>
<td>80%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
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<tr>
<td>• assessment and diagnostic services</td>
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<td>• family therapy</td>
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<td>• opioid treatment</td>
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<tr>
<td>- Outpatient hospital/outpatient behavioral health treatment facility charges for services including Intensive Outpatient Programs (IOP) and related aftercare services</td>
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<td>- Inpatient health care professional charges</td>
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<tr>
<td>- Inpatient hospital/residential behavioral health treatment facility charges</td>
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</tbody>
</table>

### NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Admissions that qualify as “emergency holds,” as the term is defined in Minnesota statutes, are considered medically necessary for the entire hold.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, physician time, or psychotherapy.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for treatment of a behavioral health diagnosis.
- For home health related services, refer to Home Health Care.

### NOT COVERED:

- treatment of attention deficit disorder with or without mention or presence of hyperactivity disorder (testing and evaluation is covered)
- services for substance abuse or addictions not listed in the most recent edition of the *International Classification of Diseases*
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary; services that are not considered medically necessary include, but are not limited to the following: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency; and domestic violence programs
• room and board for foster care, group homes, incarceration, shelter care, and lodging programs
• halfway house services
• substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person with the intent of convincing the affected person to enter treatment for the condition
• please refer to the General Exclusions section
# Chiropractic Care

<table>
<thead>
<tr>
<th>The Student Health Benefit Plan Covers:</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
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</thead>
<tbody>
<tr>
<td>Chiropractic care</td>
<td>80%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
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</tbody>
</table>

## NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Chiropractic care is limited to a maximum benefit of $500 per person per plan year when you use an Out-of-Network Provider. Lab and diagnostic imaging services does not apply to the maximum.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the chiropractor's time.

## NOT COVERED:

- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); or educational therapy (defined as special education classes, tutoring, and other non medical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work-hardening programs; etc.; and all related material and products for these programs
- services for or related to therapeutic massage
- services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized maintenance therapy to treat the member's condition
- custodial care
- please refer to the General Exclusions section
## Dental Care

<table>
<thead>
<tr>
<th>The Student Health Benefit Plan Covers:</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is not a dental plan. The following limited dental-related coverage is provided:</td>
<td>80%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
</tr>
<tr>
<td>- Accident-related dental services from a physician or dentist for the treatment of an injury to sound and healthy natural teeth</td>
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<tr>
<td>- Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including:</td>
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<td>- dental implants</td>
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<td>- removal of impacted teeth or tooth extractions</td>
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<tr>
<td>- related orthodontia</td>
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<tr>
<td>- related oral surgery</td>
<td></td>
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<tr>
<td>- bone grafts</td>
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<tr>
<td>- Surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder including:</td>
<td></td>
<td></td>
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<tr>
<td>- orthognathic surgery</td>
<td></td>
<td></td>
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<tr>
<td>- related orthodontia</td>
<td></td>
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</tbody>
</table>

**NOTES:**

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- All of the above mentioned benefits are subject to medical necessity and eligibility of the proposed treatment. Treatment must occur while you are covered under this Student Health Benefit Plan.
- The Plan covers orthodontia to repair, restore and reposition sound natural teeth that have been damaged lost or removed due to an accidental injury.
- Accident-related dental services, treatment and/or restoration of a sound and healthy natural tooth must be initiated within 12 months of the date of injury or within 12 months of your effective date of coverage under this Plan. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services performed within 24 months from the date treatment or restoration is initiated are covered. Coverage for treatment and/or restoration is limited to re-implantation of original sound and healthy natural teeth, crowns, fillings and bridges.
- The Student Health Benefit Plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted. For facility charges please refer to Hospital Inpatient or Hospital Outpatient.
- Services for surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder must be covered on the same basis as any other body joint and administered or prescribed by a physician or dentist.
- Bone grafts for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.
- A sound and healthy natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year. A dental implant is not a sound and healthy natural tooth.

**NOT COVERED:**

- all orthodontia, except as specified in the Benefit Chart
- routine dental care outside of the Boynton Health Service Dental Clinic
- dental services to treat an injury from biting or chewing
- dentures, regardless of the cause or the condition, and any associated services and/or charges, including bone grafts
- dental implants and any associated services and/or charges, except as specified in the Benefit Chart
- removal of impacted teeth and/or tooth extractions and any associated charges including but not limited to imaging studies and pre-operative examinations, except as specified in the Benefit Chart
- accident-related dental services initiated after 12 months from the date of injury or 12 months of your effective date of coverage under this Plan or occurring more than 24 months after the date of initial treatment
- replacement of a damaged dental bridge from an accident-related injury
- osteotomies and other procedures associated with the fitting of dentures or dental implants, except as specified in the Benefit Chart
- oral surgery and anesthesia for removal of a tooth root without removal of the whole tooth and root canal therapy
- services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, except as specified in the Benefit Chart
- please refer to the General Exclusions section
## Emergency Room

<table>
<thead>
<tr>
<th>The Student Health Benefit Plan Covers:</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Outpatient hospital/facility emergency room charges</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>• Outpatient health care professional charges</td>
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</tbody>
</table>

### NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- When determining if a situation is a medical emergency, the Claims Administrator will take into consideration a reasonable layperson’s belief that the circumstances required immediate medical care that could not wait until the next business day.
- For inpatient services, refer to Hospital Inpatient and Physician Services.
- For urgent care visits, refer to Hospital Outpatient and Physician Services.
- For take-home prescription drugs, refer to Prescription Drugs and Insulin.

### NOT COVERED:

- please refer to the General Exclusions section
## Gender Identity Disorder Treatment

<table>
<thead>
<tr>
<th>The Student Health Benefit Plan Covers:</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital/facility charges for medical and surgical treatment of gender identity disorder including:</td>
<td>80%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
</tr>
<tr>
<td>- semiprivate room and board and general nursing care (private room is covered only when medically necessary)</td>
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<td>- intensive care and other special care units</td>
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<td>- operating, recovery, and treatment rooms</td>
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<td>- anesthesia</td>
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<td>- prescription drugs and supplies used during a covered hospital stay</td>
<td></td>
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<tr>
<td>- lab and diagnostic imaging</td>
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<tr>
<td>Outpatient hospital/facility charges for medical and surgical treatment of gender identity disorder including:</td>
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<tr>
<td>- scheduled surgery/anesthesia</td>
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<td>- lab and diagnostic imaging</td>
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<tr>
<td>- all other outpatient hospital care</td>
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<tr>
<td>Health care professional charges for medical and surgical treatment of gender identity disorder including:</td>
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<tr>
<td>- office visit</td>
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<td>- E-Visit</td>
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<td>- lab and diagnostic imaging</td>
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<tr>
<td>- inpatient hospital/facility visits during a covered admission</td>
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<tr>
<td>- outpatient hospital/facility visits</td>
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<td>- anesthesia by a provider other than the operating or assisting provider</td>
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<td>- surgery</td>
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<td>- assistant surgeon</td>
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<tr>
<td>- injectable drugs administered by a health care professional</td>
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</tbody>
</table>
• Prescription drug charges for the treatment of gender identity disorder

For the level of coverage, refer to Prescription Drugs and Insulin.

For the level of coverage, refer to Prescription Drugs and Insulin.

NOTES:

• Prior authorization is required for gender identity disorder services. Refer to the Notification Requirements section.

• Gender identity disorder is a condition in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in their own gender. Sex reassignment refers to the process through which an individual diagnosed with gender identity disorder seeks to change his/her biological body through hormonal therapy, sex transformation surgery, or both.

• Surgery and associated services, including prescription drugs and cosmetic alteration medications for the treatment of gender identity disorder are limited to a combined maximum benefit of $50,000 per person per plan year.

• All requests for prior authorization must be submitted in writing to:

  Blue Cross and Blue Shield of Minnesota
  Utilization Management Department
  P.O. Box 64265
  St. Paul, MN 55164

• If more than one (1) surgical procedure is performed during the same operative session, the Plan covers the surgical procedures based on the allowed amount for each procedure. The Plan does not cover a charge separate from the surgery for pre-operative and post-operative care.

• Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the physician’s time.

• E-Visit is an online evaluation and management service provided by a physician using the internet or similar secure communications network to communicate with an established patient.

• Questions related to Specialty Drug coverage, refer to Boynton Health Service Pharmacy at 612-624-7655.

NOT COVERED:

• repair of scars and blemishes on skin surfaces
• separate charges for pre-operative and post-operative care for surgery
• internet or similar network communications for the purpose of: scheduling medical appointments; refilling or renewing existing prescription medications; reporting normal medical test results; providing education materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for an onsite medical office visit
• cosmetic surgery to repair a physical defect
• treatment, services or supplies which are not medically necessary
• please refer to the General Exclusions section
# Home Health Care

<table>
<thead>
<tr>
<th>The Student Health Benefit Plan Covers:</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
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<tbody>
<tr>
<td>• Skilled care and other home care services ordered by a physician and provided by employees of a Medicare approved or other preapproved home health agency including, but not limited to:</td>
<td>80%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
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<tr>
<td>• Skilled care and other home care services ordered by a physician and provided by employees of a Medicare approved or other preapproved home health agency including, but not limited to:</td>
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</table>
The Student Health Benefit Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member’s life expectancy to two (2) years or less. The services must be within the scope of the provider’s license to be covered. Palliative care does not include hospice or respite care.

**NOT COVERED:**

- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care
- charges for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury
- treatment, services or supplies which are not medically necessary
- please refer to the General Exclusions section
## Home Infusion Therapy

<table>
<thead>
<tr>
<th>The Student Health Benefit Plan Covers:</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Home infusion therapy services when ordered by a physician</td>
<td>80%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
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<tr>
<td>• Solutions and pharmaceutical additives, pharmacy compounding and dispensing services</td>
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<tr>
<td>• Durable medical equipment</td>
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<tr>
<td>• Ancillary medical supplies</td>
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<tr>
<td>• Nursing services to:</td>
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<td></td>
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<tr>
<td>▪ train you or your caregiver</td>
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<tr>
<td>▪ monitor your home infusion therapy</td>
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<tr>
<td>• Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy</td>
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<tr>
<td>• Other eligible home health services and supplies provided during the course of home infusion therapy</td>
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</tbody>
</table>

**NOTES:**

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Coverage is limited to a combined maximum benefit of $25,000 per person per plan year for Home Health Care and Home Infusion Therapy services.

**NOT COVERED:**

- home infusion services or supplies not specifically listed as covered services
- nursing services to administer therapy that you or another caregiver can be successfully trained to administer
- services that do not involve direct patient contact, such as delivery charges and recordkeeping
- please refer to the General Exclusions section
## Hospice Care

The Student Health Benefit Plan Covers:

<table>
<thead>
<tr>
<th></th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
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</thead>
<tbody>
<tr>
<td>Hospice care for a terminal condition provided by a Medicare approved hospice provider or other preapproved hospice including:</td>
<td>80%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
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<tr>
<td>• routine home care</td>
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<td>• continuous home care</td>
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<tr>
<td>• inpatient respite care</td>
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<tr>
<td>• general inpatient care</td>
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</table>

### NOTES:

- Benefits are restricted to terminally ill patients with a terminal illness (i.e. life expectancy of six (6) months or less). The patient’s primary physician must certify in writing a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a hospice program.
- Inpatient respite care is for the relief of the patient’s primary care giver and is limited to a maximum of five (5) consecutive days at a time up to a maximum of 15 days during the episode of hospice care.
- General inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Medical care services unrelated to the terminal condition are covered, but are separate from the hospice benefit.

### NOT COVERED:

- room and board expenses in a residential hospice facility
- please refer to the General Exclusions section
# Hospital Inpatient

The Student Health Benefit Plan covers:

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<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
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</thead>
<tbody>
<tr>
<td>• Semiprivate room and board and general nursing care (private room is covered only when medically necessary)</td>
<td>80%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
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<tr>
<td>• Intensive care and other special care units</td>
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<td>• Operating, recovery, and treatment rooms</td>
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<tr>
<td>• Anesthesia</td>
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<tr>
<td>• Prescription drugs and supplies used during a covered hospital stay</td>
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<td>• Lab and diagnostic imaging</td>
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<tr>
<td>• Communication services of a private duty nurse or a personal care assistant up to 120 hours during a hospital admission</td>
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</table>

**NOTES:**

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- The Plan covers kidney and cornea transplants. For kidney transplants performed in conjunction with an eligible major transplant or other kinds of transplants, refer to Transplant Coverage.
- The Plan covers the following kidney donor services when billed under the donor recipient’s name and the donor recipient is covered for the kidney transplant under the Plan *(You must be covered under the Student Health Benefit Plan for six (6) months to be eligible for transplant coverage):*
  - potential donor testing
  - donor evaluation and work-up; and
  - hospital and professional services related to organ procurement
- The Student Health Benefit Plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
- For take-home prescription drugs, refer to Prescription Drugs and Insulin.
- For gender identity disorder treatment and related services, refer to Gender Identity Disorder Treatment.

**NOT COVERED:**

- services for or related to bariatric surgery
- communication services provided on an outpatient basis or in the home
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care
- please refer to the General Exclusions section
## Hospital Outpatient

### The Student Health Benefit Plan Covers:
- Scheduled surgery/anesthesia
- Radiation and chemotherapy
- Kidney dialysis
- Respiratory therapy
- Physical, occupational, and speech therapy
- Lab and diagnostic imaging
- Diabetes outpatient self-management training and education, including medical nutrition therapy
- Palliative care
- Urgent care
- All other outpatient hospital care
- Preventive care, including lab and diagnostic imaging
- Well-child care, including lab and diagnostic imaging
- Rabies vaccine
- Sterilization for the following:
  - Surgical implants
  - Insertion and removal of implantable devices
  - Cervical cap supplies and services
  - Diaphragm supplies and services
  - Insertion and removal of IUDs

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<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
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<tr>
<td></td>
<td>80%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
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<td>Preventive care,</td>
<td>100%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
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<tr>
<td>Well-child care,</td>
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<td>Rabies vaccine</td>
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<td>Sterilization for</td>
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<td>Surgical implants</td>
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<td>Insertion and removal of implantable devices</td>
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<tr>
<td>Cervical cap</td>
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<tr>
<td>Supplies and services</td>
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<tr>
<td>Diaphragm supplies and services</td>
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<tr>
<td>Insertion and removal of IUDs</td>
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</table>

### NOTES:
- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- The Student Health Benefit Plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
• The Student Health Benefit Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member’s life expectancy to two (2) years or less. The services must be within the scope of the provider’s license to be covered. Palliative care does not include hospice or respite care.
• For take-home prescription drugs, refer to Prescription Drugs and Insulin.
• For gender identity disorder treatment and related services, refer to Gender Identity Disorder Treatment.

**NOT COVERED:**

• services for or related to bariatric surgery
• please refer to the General Exclusions section
Maternity

The Student Health Benefit Plan Covers:

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<tr>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
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<tbody>
<tr>
<td>• Health care professional services and hospital/facility charges for prenatal care</td>
<td>100%</td>
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<tr>
<td>• Health care professional services for:</td>
<td>80%</td>
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<tr>
<td>▪ delivery</td>
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<td>▪ postpartum care</td>
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<tr>
<td>• Inpatient and outpatient hospital/facility services for:</td>
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<tr>
<td>▪ delivery</td>
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<td>▪ postpartum care</td>
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</table>

NOTES:

• Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
• Refer to the Eligibility section to determine when baby’s coverage will begin.
• Group health plans such as this Student Health Benefit Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consultation with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours as applicable). In any case, the Student Health Benefit Plan may under federal law, require that a provider obtain authorization from the Claims Administrator for prescribing a length of stay greater than 48 hours (or 96 hours).
• Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the physician’s time.
• The Student Health Benefit Plan covers one (1) home health care visit within four (4) days of discharge from the hospital if either the mother or the newborn child is confined for a period less than the 48 hours (or 96 hours) mentioned above. See Home Health Care.

NOT COVERED:

• health care professional charges for deliveries in the home
• services for or related to adoption fees
• services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, and prenatal/delivery/postnatal services
• child-birth classes
• services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart
• please refer to the General Exclusions section
Medical Equipment, Prosthetics, and Supplies

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<tr>
<th>The Student Health Benefit Plan Covers:</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
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</thead>
<tbody>
<tr>
<td>Durable medical equipment (DME), including wheelchairs, ventilators, oxygen, oxygen equipment, and hospital beds</td>
<td>80%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
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<td>Medical supplies, including splints, nebulizers, surgical stockings, casts, and dressings</td>
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<td>Insulin pumps, glucometers and related equipment and devices</td>
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<td>Blood, blood plasma, and blood clotting factors</td>
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<td>Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes</td>
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<td>Special dietary treatment for Phenylketonuria (PKU) when recommended by a physician</td>
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<td>Corrective lenses for aphakia</td>
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<td>Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years</td>
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<td>Custom foot orthoses only if you have a diagnosis of diabetes with neurological manifestations of one (1) or both feet</td>
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<tr>
<td>Sterilization for the following:</td>
<td>100%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
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<tr>
<td>▪ surgical implants</td>
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<td>▪ insertion and removal of implantable devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ cervical cap supplies and services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ diaphragm supplies and services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ insertion and removal of IUDs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual hand operated breast pump</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses and frames for refractive errors for children age 18 and younger. Includes frames and single vision, bifocal, tri-focal, and lenticular lenses. Maximum benefit of $100 per person per plan year.</td>
<td>100%</td>
<td>NO COVERAGE.</td>
</tr>
</tbody>
</table>

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Durable medical equipment is covered up to the allowed amount to rent or buy the item. Allowable rental charges are limited to the allowed amount to buy the item.
• Coverage for durable medical equipment will not be excluded solely because it is used outside the home.
• For coverage of insulin and diabetic supplies, refer to Prescription Drugs and Insulin.
• For hearing aid exam services, refer to Physician Services.

NOT COVERED:

• solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the Benefit Chart
• personal and convenience items or items provided at levels which exceed the Claims Administrator’s determination of medically necessary
• services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats; feeding chairs; pillows; food or weight scales; hot tubs; whirlpools; and incontinence pads or pants
• modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps
• blood pressure monitoring devices
• phototherapy devices and/or bulbs for seasonal affective disorder (SAD)
• communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient’s medical condition would deteriorate
• services for or related to lenses, frames, contact lenses, or other fabricated optical devices or professional services to fit or supply them, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart
• duplicate equipment, prosthetics, or supplies
• foot orthoses, except as provided in the Benefit Chart
• scalp/cranial hair prostheses (wigs)
• services for or related to hearing aids or devices, except as specified in the Benefit Chart
• non-prescription supplies such as alcohol, cotton balls and alcohol swabs
• sleep apnea appliance
• electric or hospital grade breast pump
• please refer to the General Exclusions section
Physical Therapy, Occupational Therapy, Speech Therapy

The Student Health Benefit Plan Covers:

<table>
<thead>
<tr>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits from a physical therapist, occupational therapist, speech or language pathologist</td>
<td>80%</td>
</tr>
<tr>
<td>Therapies</td>
<td>For the level of coverage, refer to Physician Services.</td>
</tr>
</tbody>
</table>

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Physical, speech, and occupational therapy services are limited to a combined maximum benefit of $500 per person per plan year when you use an Out-of-Network Provider.
- Office visits may include a physical therapy evaluation or re-evaluation, occupational therapy evaluation or re-evaluation, or speech or swallowing evaluation.

NOT COVERED:

- services primarily educational in nature, except as specified in the Benefit Chart
- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); or educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work-hardening programs; etc.; and all related material and products for these programs
- services for or related to therapeutic massage
- physical, occupational, and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider
- services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable amount of time, unless they are medically necessary and are part of specialized maintenance therapy for the member’s condition
- custodial care
- please refer to the General Exclusions section
### UMC Physician Services Benefits

**The Student Health Benefit Plan Covers:**

<table>
<thead>
<tr>
<th>Professional charges for outpatient treatment rendered at UMC Health Service when insured has paid Student Services Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>UMC Health Service with payment of Student Services Fee</td>
</tr>
<tr>
<td>100% of available services</td>
</tr>
</tbody>
</table>

### Physician Services

**The Student Health Benefit Plan Covers:**

<table>
<thead>
<tr>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office visits</strong></td>
<td></td>
</tr>
<tr>
<td>- illness</td>
<td>80%</td>
</tr>
<tr>
<td>- urgent care</td>
<td></td>
</tr>
<tr>
<td>- E-Visit</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
</tr>
<tr>
<td><strong>Allergy testing and injections</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes outpatient self-management training and education, including medical nutrition therapy</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Lab and diagnostic imaging</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient hospital/facility visits during a covered admission</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient hospital/facility visits</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Anesthesia by a provider other than the operating, delivering, or assisting provider</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Surgery, including sterilization (for services other than surgery, see below)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Assistant surgeon</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Injectable drugs administered by a health care professional</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Palliative care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Retail health clinic services including, but not limited to office visits and lab services</strong></td>
<td>100% after you pay the retail health clinic copay.</td>
</tr>
<tr>
<td>100% after you pay the retail health clinic copay, plus you pay any charges billed to you that exceed the allowed amount.</td>
<td></td>
</tr>
</tbody>
</table>
- Rabies vaccine
- Sterilization for the following:
  - surgical implants
  - insertion and removal of implantable devices
  - cervical cap supplies and services
  - diaphragm supplies and services
  - insertion and removal of IUDs

| 100% | 80%, plus you pay any charges billed to you that exceed the allowed amount. |

NOTES:
- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Please refer to UMC Health Service (page 31) for your highest level of coverage.
- If more than one (1) surgical procedure is performed during the same operative session, the Student Health Benefit Plan covers the surgical procedures based on the allowed amount for each procedure. The Student Health Benefit Plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
- The Student Health Benefit Plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- You are entitled to receive care at the In-Network level for the following services from providers who are not affiliated with the Claims Administrator:
  - the voluntary planning of the conception and bearing of children;
  - the diagnosis of infertility;
  - the testing and treatment of a sexually transmitted disease; or
  - the testing of AIDS or other HIV-related conditions.
- The Student Health Benefit Plan covers certain physician services for preventive care. Refer to Preventive Care.
- For kidney transplants performed in conjunction with an eligible major transplant, refer to Transplant Coverage.
- The Plan covers certain patient costs for approved clinical trials. Routine patient costs include items and services that would be covered for members who are not enrolled in an approved clinical trial.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the physician’s time.
- E-Visit is an on-line evaluation and management service provided by a physician using the internet or similar secure communications network to communicate with an established patient.
- A retail health clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail health clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis.
- The Student Health Benefit Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member’s life expectancy to two (2) years or less. The services must be within the scope of the provider’s license to be covered. Palliative care does not include hospice or respite care.
- The Plan covers hearing aid exams/fittings/adjustments for children age 18 and younger.
- For gender identity disorder treatment and related services, refer to Gender Identity Disorder Treatment.

NOT COVERED:
- services for or related to bariatric surgery
- allergy serum, except that the Student Health Benefit Plan does cover injections
- circumcisions done for routine purposes and/or not medically necessary
• sleep studies including but not limited to, diagnostic and therapeutic services provided for sleep related disorders
• repair of scars and blemishes on skin surfaces
• separate charges for pre-operative and post-operative care for surgery
• internet or similar network communications for the purpose of: scheduling medical appointments; refilling or renewing existing prescription medications; reporting normal medical test results; providing education materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for an onsite medical office visit
• cosmetic surgery to repair a physical defect
• travel expenses for a kidney donor
• kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
• kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
• services and supplies for professional and facility sexual dysfunction or inadequacy procedures
• please refer to the General Exclusions section
### Prescription Drugs and Insulin

<table>
<thead>
<tr>
<th>Cover</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>100% after you pay the applicable member cost-sharing when you present your ID card or otherwise provide notice of coverage at the time of purchase. Refer to Prescription Drugs in the Benefit Chart.</td>
<td>100% after you pay the applicable member cost-sharing, plus you pay any charges billed to you that exceed the allowed amount. You must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself. Refer to Prescription Drugs in the Benefit Chart.</td>
</tr>
<tr>
<td><strong>Prescription drugs</strong></td>
<td>✪ insulin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✪ prescribed drug therapy supplies including, but not limited to: blood/urine testing tabs/strips; needles and syringes; and lancets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✪ prescription injectable drugs that are self-administered</td>
<td></td>
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<tr>
<td></td>
<td>✪ tobacco cessation drugs and products, including over-the-counter tobacco cessation products</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✪ amino acid-based elemental formula</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✪ prescription prenatal vitamins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✪ prescription pediatric multivitamins with fluoride</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✪ prescription drugs for or related to the treatment of gender identity disorder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✪ cosmetic alteration medications for or related to the treatment of gender identity disorder</td>
<td></td>
</tr>
<tr>
<td><strong>Designated oral contraceptive drugs as defined by the group</strong></td>
<td>100%</td>
<td>100%, plus you pay any charges billed to you that exceed the allowed amount. You must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself.</td>
</tr>
<tr>
<td><strong>Contraceptive management for the following:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>✪ injectable contraceptives</td>
<td></td>
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<tr>
<td></td>
<td>✪ Plan B One-Step (Levonorgestrel) (emergency contraceptive)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✪ diaphragm</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✪ intrauterine device</td>
<td></td>
</tr>
<tr>
<td><strong>Designated over-the-counter (OTC) drugs with a prescription</strong></td>
<td>100% when you present your ID card or otherwise provide notice of coverage at the time of purchase.</td>
<td>NO COVERAGE</td>
</tr>
</tbody>
</table>

### NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- For information regarding the above contraceptive coverage, please visit the Claims Administrator’s website or contact Customer Service.
• You must present your ID card or otherwise provide notice of coverage at the time of purchase to receive the highest level of benefits. If you do not present your ID card or otherwise provide notice of coverage at the time of purchase, the pharmacy will charge you the full amount of the prescription drug. You will be reimbursed based on the discounted pricing. Therefore, in addition to any applicable member cost-sharing, you will also be liable for the difference between the amount the pharmacy charges you for the prescription drug at the time of purchase and any discounted pricing the Claims Administrator has negotiated with participating pharmacies for that prescription drug.

• You have the option to obtain up to a 90-day authorized supply of ongoing, long-term prescription medications through a participating 90dayRx retail pharmacy or mail service pharmacy for your ongoing, long-term refills. You may visit the Claims Administrator’s website or contact Customer Service to locate a retail pharmacy participating in the 90dayRx Network or mail service pharmacy.

• The following ADHD medications are eligible with no quantity limitations; mixed amphetamine salts (Adderall generic only) - immediate release (no coverage for extended release); methylphenidate 5mg, 10mg, 20mg, SR (not ER); dextroamphetamine 5mg, 10mg (Dexedrine generic only); Strattera and Amphetamine/Dextroamphetamine 5mg and 10 mg (manufactured by Mallinckrodt).

• Surgery and associated services, including prescription drugs and cosmetic alteration medications for the treatment of gender identity disorder are limited to a combined maximum benefit of $50,000 per person per plan year.

• Prescription drugs and diabetic supplies are generally covered in a 30-day supply from a retail pharmacy or up to a 90-day supply from a 90dayRx. Some medications may be subject to a quantity limitation per days supply or to a maximum dosage per day.

• Up to 3-cycle supply of self-administered oral contraceptives may be purchased at a retail pharmacy at one time for one (1) copay, or for one copay per cycle.

• Designated Over-the-Counter (OTC) drugs are generally covered up to a 31-day supply, as an alternative for similar prescription medications, subject to package limitations, at a retail participating pharmacy. OTC drugs are not available through 90dayRx.

• If you choose a brand name drug when there is an equivalent generic drug, you will also pay the difference in cost between the brand name and the generic drug, in addition to the applicable member cost-sharing.

• The Plan covers prescription tobacco cessation drugs and products and over-the-counter (OTC) tobacco cessation drugs and products with a physician’s prescription subject to your applicable member cost-sharing. Participants in Stop-Smoking Support may use documented enrollment in place of a physician’s prescription for OTC tobacco cessation drugs and products. Some quantity limitation may apply.

• The Plan will cover off label drugs used for cancer treatment as specified by law.

• When identical chemical entities including OTC drugs and similar prescription alternatives, are from different manufacturers or distributors, the Claims Administrator’s Coverage Committee may determine that only one of those drug products is covered and the other equivalent products are not covered.

• To locate a participating pharmacy in your area, call the pharmacy information telephone number provided in the Customer Service section.

• For drugs dispensed and used during an admission, refer to Hospital Inpatient.

• For supplies or appliances, except as provided in this Benefit Chart, refer to Medical Equipment, Prosthetics and Supplies.

• When you pay for your prescription drugs, insulin and drug therapy supplies yourself, you are required to submit the drug receipt(s) with the claim form for reimbursement.

• The Plan Administrator and/or the Claims Administrator may receive pharmaceutical manufacturer volume discounts in connection with the purchase of certain prescription drugs covered under the Plan. Such discounts are the sole property of the Plan Administrator and/or Claims Administrator and will not be considered in calculating any coinsurance, copay, or benefit maximums.

• Questions related to Specialty Drug coverage, refer to Boynton Health Service Pharmacy at 612-624-7655.

**NOT COVERED:**

• charges for giving injections that can be self-administered
• over-the-counter drugs, except as specified in the Benefit Chart
• investigative or non-FDA approved drugs, except as required by law
• vitamin or dietary supplements, except as specified in the Benefit Chart
• Specialty drugs
• prescription drugs for or related to assisted reproductive technology (ART)
• medication for treatment of sexual dysfunction, including, but not limited to erectile dysfunction
- non-prescription supplies such as alcohol, cotton balls and alcohol swabs
- selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety or side effects
- weight loss medications
- oral contraceptives, except as specified in the Benefit Chart
- cosmetic alteration medications, except as specified in the Benefit Chart
- please refer to the General Exclusions section
# UMC Preventive Care Benefits

<table>
<thead>
<tr>
<th>The Student Health Benefit Plan Covers:</th>
<th>UMC Health Service with payment of Student Services Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine physical exams</td>
<td>100% of available services</td>
</tr>
<tr>
<td>Lab (i.e. for pregnancy) and x-ray</td>
<td></td>
</tr>
</tbody>
</table>

## Preventive Care

<table>
<thead>
<tr>
<th>The Student Health Benefit Plan Covers:</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer screening as specified below:</td>
<td>100%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
</tr>
<tr>
<td>- mammograms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- pap smears</td>
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<td></td>
</tr>
<tr>
<td>- flexible sigmoidoscopies and/or screening fiberoptic colonoscopies</td>
<td></td>
<td></td>
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<tr>
<td>- fecal occult blood testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Prostate Specific Antigen (PSA) tests, digital rectal exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- surveillance tests for ovarian cancer (CA125 tumor marker, trans-vaginal ultrasound, pelvic exam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Prostate Specific Antigen (PSA) tests, digital rectal exams</td>
<td></td>
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</tr>
<tr>
<td>- surveillance tests for ovarian cancer (CA125 tumor marker, trans-vaginal ultrasound, pelvic exam)</td>
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<tr>
<td>- fecal occult blood testing</td>
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<td></td>
</tr>
<tr>
<td>- Prostate Specific Antigen (PSA) tests, digital rectal exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- surveillance tests for ovarian cancer (CA125 tumor marker, trans-vaginal ultrasound, pelvic exam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive medical evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynecological exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing screening, one (1) per plan year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision exam (glaucoma, acuity, and refraction), one (1) per plan year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Immunizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic imaging services as specified below:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- osteoporosis screening (radiology services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Abdominal Aortic Aneurysm (AAA) ultrasound screening</td>
<td></td>
<td></td>
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<tr>
<td>Lab services as specified below:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- lipid profile, including total cholesterol and HDL cholesterol</td>
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<tr>
<td>- thyroid screening</td>
<td></td>
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</tr>
<tr>
<td>- diabetes screening</td>
<td></td>
<td></td>
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<tr>
<td>- hemoglobin – CBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- urinalysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- screening for chlamydia, gonorrhea, syphilis and HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rabies vaccine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NOTES:

- Please refer to UMC Health Service (page 31) for you highest level of coverage.
- The Plan covers the purchase of a manual hand operated breast pump.
- Benefits for services identified as preventive care are determined based on recommendations and criteria established by professional associations and experts in the field of preventive care (e.g., Institute for Clinical Systems Improvement (ICSI), United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), etc.). For all other eligible services, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- Eligible standard immunizations (e.g., diphtheria, tetanus, etc.) are covered under the Preventive Care benefit based on recommendations and criteria established by professional associations and experts in the field of Preventive Care. For nonstandard immunizations including, but not limited to: malaria; rabies; typhoid; gamma globulin; tetanus immune globulin; and yellow fever, refer to Physician Services.
- Services to treat an illness/injury diagnosed as a result of preventive care services may be covered under other Plan benefits. Refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- You are entitled to receive care at the In-Network level for the following services: screening for sexually transmitted disease or HIV.
- For hospital/facility charges, refer to Hospital Outpatient.

NOT COVERED:

- services for or related to surrogate pregnancy including diagnostic screening, physician services, reproduction treatments, and prenatal/delivery/postnatal services
- services for or related to preventive medical evaluations for purpose of medical research, NCAA sports participation, obtaining employment or insurance, obtaining/maintaining a license of any type, or other administrative or participation exams, unless such preventive medical evaluation would normally have been provided in the absence of the third party request
- a general medical examination requested by a third party for: admission to an old age home, adoption, camp, driving license, immigration and naturalization, insurance certification, marriage, prison, school admission or sports competition
- educational classes or programs
- services for or related to lenses, frames, and contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except where eligible under Medical Equipment, Prosthetics, and Supplies
- electric or hospital grade breast pump
- please refer to the General Exclusions section
# Reconstructive Surgery

## The Student Health Benefit Plan Covers:

- Reconstructive surgery which is incidental to or following surgery resulting from injury, sickness, or other diseases of the involved body part
- Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician
- Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including dental implants
- Elimination or maximum feasible treatment of port wine stains

<table>
<thead>
<tr>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.</td>
<td>For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.</td>
</tr>
</tbody>
</table>

## NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Under the Federal Women’s Health and Cancer Rights Act of 1998, you are entitled to the following services: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema). Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.
- Congenital means present at birth.
- Bone grafting for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.
- For gender identity disorder treatment and related services, refer to Gender Identity Disorder Treatment.

## NOT COVERED:

- repair of scars and blemishes on skin surfaces
- dentures, regardless of the cause or condition, and any associated services and/or charges including bone grafts
- dental implants and any associated services and/or charges, except as specified in the Benefit Chart
- please refer to the General Exclusions section
## Skilled Nursing Facility

<table>
<thead>
<tr>
<th>The Student Health Benefit Plan Covers:</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Skilled care ordered by a physician</td>
<td>80%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
</tr>
<tr>
<td>• Semiprivate room and board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• General nursing care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prescription drugs used during a covered admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical, occupational, and speech therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- You must be admitted within 14 days after hospital admission of at least three (3) consecutive days for the same illness.
- For take-home prescription drugs, refer to Prescription Drugs and Insulin.

### NOT COVERED:

- charges for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury
- treatment, services or supplies which are not medically necessary
- please refer to the General Exclusions section
### Transplant Coverage

<table>
<thead>
<tr>
<th>The Student Health Benefit Plan Covers:</th>
<th>Blue Distinction Centers for Transplant (BDCT) Providers</th>
<th>Non-Blue Distinction Centers for Transplant (BDCT) Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following medically necessary human organ, bone marrow, cord blood and peripheral stem cell transplant procedures:</td>
<td>100% of the Transplant Payment Allowance for the transplant admission. If you live more than 50 miles from a BDCT Provider, there may be travel benefits available for expenses directly related to a preauthorized transplant. See NOTES. For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.</td>
<td>Participating Transplant Provider 80% of the Transplant Payment Allowance for the transplant admission, plus you pay any charges billed to you that exceed the allowed amount. For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage. Nonparticipating Transplant Provider NO COVERAGE.</td>
</tr>
<tr>
<td>• Allogeneic and syngeneic bone marrow transplant and peripheral stem cell transplant procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Autologous bone marrow transplant and peripheral stem cell transplant procedures</td>
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<tr>
<td>• Heart</td>
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<td></td>
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<tr>
<td>• Heart - lung</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Kidney – pancreas transplant performed simultaneously (SPK)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Liver – deceased donor and living donor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lung – single or double</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pancreas transplant – deceased donor and living donor segmental</td>
<td></td>
<td></td>
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<tr>
<td>▪ Pancreas Transplant Alone (PTA)</td>
<td></td>
<td></td>
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<tr>
<td>▪ Simultaneous Pancreas – Kidney transplant (SPK)</td>
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<tr>
<td>▪ Pancreas transplant After Kidney transplant (PAK)</td>
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<td></td>
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<tr>
<td>• Small-bowel and small-bowel/liver</td>
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</tbody>
</table>

**NOTES:**

- **You must be covered under the Student Health Benefit Plan for six (6) months to be eligible for transplant coverage.**
- Kidney transplants when not performed in conjunction with an eligible major transplant noted above and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Refer to Hospital Inpatient and Physician Services.
- **Prior authorization is required for human organ, bone marrow, cord blood and peripheral stem cell transplant procedures and should be submitted in writing to the Transplant Coordinator at P. O. Box 64179, St. Paul, Minnesota, 55164, or faxed to 651-662-1624.**
Eligible transplant services provided by Participating Transplant Providers will be paid at the Blue Distinction Centers for Transplant (BDCT) Provider level of benefits when the transplant services are not available at a BDCT Provider.

Travel benefit- Eligible when you travel more than 50 miles to obtain transplant care at a BDCT or when the BDCT provider requires you to stay at or nearby the transplant facility.

- The Plan covers the patient up to $50 per day for lodging when purchased at the transplant facility.
- The Plan covers a companion/caregiver up to $50 per day for lodging.
- The Plan covers the lesser of: 1) the IRS medical mileage allowance in effect on the dates of travel per an online web mapping service or, 2) airline ticket price paid. Mileage applies to the patient traveling to and from home and the BDCT only.
- Total benefit shall not exceed $5,000 per lifetime.
- Lodging is eligible when staying at apartments, hotels, motels, or hospital patient lodging facilities and is eligible only when an overnight stay is necessary.
- Reimbursed expenses are not tax deductible. Consult your tax advisor.

**NOT COVERED:**

- travel benefits when you are using a Non-BDCT Provider
- services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart
- services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- services, supplies, drugs, and aftercare for or related to human organ transplants not specifically listed above as covered
- services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures that are considered investigatory or not medically necessary
- living donor organ and/or tissue transplants unless otherwise specified in this Summary Plan Description
- transplantation of animal organs and/or tissue
- non-covered travel expenses include but are not limited to: meals; utilities; child care; pet care; security deposits; cable hook-up; dry cleaning; laundry; car rental; and personal items
- travel lodging is not eligible when staying with family or friends
- services you receive from a Nonparticipating Provider
- please refer to the General Exclusions section

**DEFINITIONS:**

- **BDCT Provider** means a hospital or other institution that has a contract with the Blue Cross and Blue Shield Association* to provide human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures. These providers have been selected to participate in this nationwide transplant network based on their ability to meet defined clinical criteria that are unique for each type of transplant. Once selected for participation, institutions are re-evaluated annually to insure that they continue to meet the established criteria for participation in this network.
- **Participating Transplant Provider** means a hospital or other institution that has a contract with the Claims Administrator or with the local Blue Cross and/or Blue Shield Plan to provide human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures.
- **Transplant Payment Allowance** means the amount the Plan pays for covered services to a BDCT Provider or a Participating Transplant Provider for services related to human organ, bone marrow, cord blood and peripheral stem cell transplant procedures in the agreement with that provider.

*An association of independent Blue Cross and Blue Shield Plans.
## Well-Child Care

<table>
<thead>
<tr>
<th>The Student Health Benefit Plan Covers:</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following services for a dependent child from birth to age six (6):</td>
<td>100%</td>
<td>80%, plus you pay any charges billed to you that exceed the allowed amount.</td>
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<tr>
<td>- preventive services</td>
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<td>- developmental assessments</td>
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<td>- laboratory services</td>
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<tr>
<td>- immunizations</td>
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</tbody>
</table>

### NOT COVERED:

- For hospital/facility charges, refer to Hospital Outpatient.
- please refer to the General Exclusions section
The Student Health Benefit Plan does not pay for:

1. Treatment, services, or supplies which are not medically necessary.

2. Charges for or related to care that is investigative, except for certain routine care for approved clinical trials.

3. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as specified in the Benefit Chart.

4. Services that are provided without charge, including services of the clergy.

5. Services performed before the effective date of coverage, and services received after your coverage terminates, even though your illness started while coverage was in force.

6. Services for or related to therapeutic acupuncture, except for the treatment of chronic pain (defined as a duration of at least six (6) months) or for the prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy.

7. Services that are provided to you for the treatment of an employment-related injury for which you are entitled to make a workers' compensation claim.

8. Charges that are eligible, paid or payable, under any medical payment, personal injury protection, automobile or other coverage (e.g., homeowner’s insurance, boat owner’s insurance, liability insurance, etc.) that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement of such a policy.

9. Services a provider gives to himself/herself or to a close relative (such as spouse, brother, sister, parent, grandparent, and/or child).

10. Services needed because you engaged in an illegal occupation, or committed or attempted to commit a felony, unless the services are related to an act of domestic violence or the illegal occupation or felonious act is related to a physical or mental health condition.

11. Services to treat illnesses/injuries that occur while on military duty and are recognized by the Veterans Administration as services related to service-connected illnesses/injuries.

12. Services for dependents if you have participant-only coverage.

13. Services that are prohibited by law or regulation.

14. Services which are not within the scope of licensure or certification of a provider.

15. Charges for furnishing medical records or reports and associated delivery charges.

16. Services for or related to transportation, other than local ambulance service to the nearest medical facility equipped to treat the illness or injury, except as specified in the Benefit Chart.

17. Travel, transportation, or living expenses, whether or not recommended by a physician, except as specified in the Benefit Chart.

18. Services for or related to bariatric surgery.

19. Services for or related to mental illness not listed in the most recent edition of the International Classification of Diseases.

20. Services or confinements ordered by a court or law enforcement officer that are not medically necessary.
21. Evaluations that are not performed for the purpose of diagnosing or treating mental health or substance abuse conditions such as: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency; and domestic violence programs.

22. Services for or related to room and board for foster care, group homes, incarceration, shelter care, and lodging programs, halfway house services, and skills training.

23. Services for or related to intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (IEIBTS); Intensive Behavioral Intervention (IBI); and Lovaas Therapy.

24. Services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats; encounters; or seminars.

25. Services for or related to marriage/couples counseling.

26. Services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child’s improved functioning); treatment of learning disabilities; therapeutic day care and therapeutic camp services; and hippotherapy (equine movement therapy).

27. Charges made by a health care professional for physician/patient telephone consultations.

28. Services for or related to substance abuse or addictions not listed in the most recent edition of the International Classification of Diseases.

29. Services for or related to substance abuse interventions (defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person) with the intent of convincing the affected person to enter treatment for the condition.

30. Services for or related to therapeutic massage.

31. Dentures, regardless of the cause or condition, and any associated services and/or charges including bone grafts.

32. Dental implants and associated services and/or charges, except as specified in the Benefit Chart.

33. Services for or related to the replacement of a damaged dental bridge from an accident-related injury.

34. Services for or related to oral surgery and anesthesia for the removal of impacted teeth, except as specified in the Benefit Chart.

35. Services for or related to oral surgery and anesthesia for removal of a tooth root without removal of the whole tooth and root canal therapy.

36. Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts, except as specified in the Benefit Chart.

37. Room and board expenses in a residential hospice facility.

38. Inpatient hospital room and board expense that exceeds the semiprivate room rate, unless a private room is approved by the Claims Administrator as medically necessary.

39. Admission for diagnostic tests that can be performed on an outpatient basis.

40. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

41. Personal comfort items, such as telephone, television, etc.

42. Communication services provided on an outpatient basis or in the home.
43. Services and prescription drugs for or related to gender selection.

44. Services and prescription drugs for or related to reproduction treatment including assisted reproductive technology (ART), artificial insemination (AI), and intrauterine insemination (IUI) procedures.

45. Services and prescription drugs for or related to gender identity disorder, sex hormones related to surgery, related preparation and follow-up treatment, care and counseling, unless medically necessary as determined by the Claims Administrator prior to receipt of services.

46. Services for or related to adoption fees and childbirth classes.

47. Services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services.

48. Donor ova or sperm.

49. Services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart.

50. Solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the Benefit Chart.

51. Services and supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hot tubs; whirlpools; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats, feeding chairs; pillows; food or weight scales; and incontinence pads or pants.

52. Modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps.


54. Foot orthoses, except as specified in the Benefit Chart.

55. Scalp/cranial hair prostheses (wigs).

56. Electric or hospital grade breast pumps.

57. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient’s medical condition would deteriorate.

58. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart.

59. Services for or related to hearing aids or devices, except as specified in the Benefit Chart.

60. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.

61. Services primarily educational in nature, except as specified in the Benefit Chart.

62. Services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider.

63. Physical, occupational and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider.

64. Services for or related to health clubs and spas.
65. Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized maintenance therapy for the member’s condition.

66. Custodial care.

67. Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self care or self-help training including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work hardening programs; etc.; and all related material and products for these programs.

68. Services for or related to functional capacity evaluations for vocational purposes and/or the determination of disability or pension benefits.

69. Services for or related to the repair of scars and blemishes on skin surfaces.

70. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.

71. Services for or related to cosmetic health services or reconstructive surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as specified in the Benefit Chart.

72. Services for or related to travel expenses for a kidney donor; kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan; and kidney donor expenses when the recipient is not covered under this Plan.

73. Services for or related to any treatment, equipment, drug, and/or device that the Claims Administrator determines does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment; services for or related to homeopathy, or chelation therapy that the Claims Administrator determines is not medically necessary.

74. Services for or related to gene therapy as a treatment for inherited or acquired disorders.

75. Services for or related to growth hormone replacement therapy except for conditions that meet medical necessity criteria.

76. Autopsies.

77. Charges for failure to keep scheduled visits.

78. Charges for giving injections that can be self-administered.

79. Internet or similar network communications for the purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.

80. Services for or related to transcranial magnetic stimulation therapy.

81. Services for or related to smoking cessation program fees and/or supplies, except as specified in the Special Features section.

82. Charges for over-the-counter drugs, except as specified in the Benefit Chart.

83. Vitamin or dietary supplements, except as specified in the Benefit Chart.

84. Investigative or non-FDA approved drugs, except as required by law.
85. Services for or related to preventive medical evaluations for purpose of medical research, NCAA sports participation, obtaining employment or insurance, obtaining/maintaining a license of any type, or other administrative or participation exams, unless such preventive medical evaluation would normally have been provided in the absence of the third party request.

86. A general medical examination requested by a third party for: admission to an old age home, adoption, camp, driving license, immigration and naturalization, insurance certification, marriage, prison, school admission or sports competition

87. Services, supplies, drugs and aftercare for or related to artificial or nonhuman organ implants.

88. Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs and aftercare for or related to bone marrow and peripheral stem cell transplant procedures that are considered investigative or not medically necessary.

89. Services for or related to fetal tissue transplantation.

90. Services for or related to bone marrow or organ transplants, including all related follow-up treatment, exams, and drugs within 365 days after the transplant when services are received prior to being on the Student Health Benefit Plan for six (6) months. Except when provided in conjunction with an eligible major organ transplant, the Plan covers kidney and cornea transplants as standard benefits.

91. Services and supplies for or related to sexual dysfunction.

92. Paternal DNA Testing.

93. For international students, expenses incurred within the insured person’s home country or country of regular domicile.

94. Expenses incurred for services or supplies for the diagnosis and treatment of sleep disorder, including, but not limited to apnea monitoring and sleep studies.
**Termination Events**

Coverage ends on the earliest of the following dates:

1. For you and your dependents, the date on which the Student Health Benefit Plan terminates.

2. For you and your dependents, the date on which:
   a. you are no longer eligible.
   b. you enter military services for duty lasting more than 31 days.

3. For the spouse, the date the spouse is no longer eligible for coverage. This is the date on which the participant and spouse divorce.

4. For a dependent child, the date the dependent child is no longer eligible for coverage. This is the date on which:
   a. a covered stepchild is no longer eligible because the participant and spouse divorce.
   b. the dependent child reaches the dependent-child age limit.
   c. the disabled dependent is no longer eligible.

5. The date on which the enrolled and domestic partner submit an “Affidavit of Termination of Domestic Partnership.”

**Extension of Benefits**

If you or your dependent is confined as an inpatient on the date coverage ends due to the replacement of the Claims Administrator, the Student Health Benefit Plan will automatically extend coverage until the date you or your dependent is discharged from the facility or the date Plan maximums are reached, whichever is earlier. Coverage is extended only for the person who is confined as an inpatient, and only for inpatient charges incurred during the admission. For purposes of this provision, “replacement” means that the administrative service agreement with the Claims Administrator has been terminated and your participant maintains continuous group coverage with a new claims administrator or insurer.
This section applies when you have health care coverage under more than one (1) plan, as defined below. If this section applies, you should look at the Order of Benefits Rules first to determine which plan determines benefits first. Your benefits under This Student Health Benefit Plan are not reduced if the Order of Benefits Rules require this Plan to pay first. Your benefits under This Student Heath Benefit Plan may be reduced if another plan pays first.

Definitions
These definitions apply only to this section.

1. The term “plan” means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:
   a. 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
   b. coverage under a government plan or required or provided by law;
   c. individual coverage; and
   d. the medical payment (“medpay”) or personal injury protection benefit available to you under an automobile insurance policy.

Therefore, “plan” does not include:
   a. 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);
   b. any benefits that, by law, are excess to any private or other nongovernmental program; or
   c. hospital indemnity, specified accident, specified disease, or limited benefit insurance policies.

Each contract or other arrangement for coverage is a separate plan. Also, if an arrangement has two (2) parts and the section applies only to one (1) part, each of the parts is a separate plan.

2. The term “This Student Health Benefit Plan” means the part of the Plan document that provides health care benefits.

3. “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 (2) plans, This Plan may be a Primary Plan to some plans, and may be a Secondary Plan to other plans.

Notes:

a. If you are covered under This Plan and Medicare: This Plan will comply with Medicare Secondary Payor (MSP) provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which Plan is a primary Plan and which is a Secondary Plan. Medicare will be primary and This Plan will be secondary only to the extent permitted by MSP rules. When Medicare is the Primary Plan, This Plan will coordinate benefits up to Medicare’s allowed amount.

b. If you are covered under this Plan and TRICARE: This Plan will comply with the TRICARE provisions of federal law, rather than the Order of Benefit’s Rules in this section, to determine which Plan is a Primary Plan and which is a Secondary Plan. TRICARE will be primary and this Plan will be secondary only to the extent permitted by TRICARE rules. When TRICARE is the Primary Plan, This Plan will coordinate benefits up to TRICARE’s allowed amount.
4. “Allowable expense” means the necessary, reasonable, and customary items of expense for health care, covered at least in part by one (1) 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 Student Health Benefit Plan. “Allowable Expense” does not include outpatient prescription drugs, except those eligible under Medicare (see number three (3) above).

The difference between the cost of a private and a semiprivate hospital room is not considered an allowable expense unless admission to a private hospital room is medically necessary under generally accepted medical practice or as defined under This Student Health Benefit 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.

5. “Claim determination period” means a plan year. However, it does not include any part of the year the person is not covered under This Student Health Benefit Plan, or any part of a year before the date this section takes effect.

Order of Benefits Rules
1. General: When a claim is filed under This Student Health Benefit Plan and another plan, This Student Health Benefit Plan is a Secondary Plan and determines benefits after the other plan, unless:
   a. the other plan has rules coordinating its benefits with This Student Health Benefit Plan’s benefits; and
   b. the other plan’s rules and This Student Health Benefit Plan’s rules, in part 2. below, require This Student Health Benefit Plan to determine benefits before the other plan.

2. Rules: This Student Health Benefit Plan determines benefits using the first of the following rules that applies:
   a. The plan that covers a person as automobile insurance medical payment ("medpay") or personal injury protection coverage determines benefits before a plan that covers a person as a group health plan enrollee.
   b. Nondependent/dependent: The plan that covers the person as a student, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.
   c. Dependent child of parents not separated or divorced: When This Student Health Benefit Plan and another plan cover the same child as a dependent of different persons, called “parents”:
      1) 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
      2) 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, and instead the other plan 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.
   d. Dependent child of parents divorced or separated or separated through termination of a domestic partner relationship: If two (2) or more plans cover a dependent child of divorced or separated parents, This Student Health Benefit Plan determines benefits in this order:
      1) first, the plan of the parent with physical custody of the child;
      2) then, the plan that covers the spouse of the parent with physical custody of the child;
      3) finally, the plan that covers the parent not having physical custody of the child; or
      4) in the case of joint physical custody, b. above applies.
However, if the court decree requires one (1) 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.

e. 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). If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.

f. Longer/shorter length of coverage: If none of the above 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 a shorter time.

**Effect on Benefits of This Student Health Benefit Plan**

1. When this section applies: When the Order of Benefits Rules above require This Student Health Benefit Plan to be a Secondary Plan, this part applies. Benefits of This Student Health Benefit Plan may be reduced.

2. Reduction in This Student Health Benefit Plan’s benefits

   When the sum of:

   a. the benefits payable for allowable expenses under This Student Health Benefit Plan, without applying coordination of benefits; and

   b. 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, exceeds those allowable expenses in a claim determination period. In that case, the benefits of This Student Health Benefit Plan are reduced so that benefits payable under all plans do not exceed allowable expenses.

When benefits of This Student Health Benefit Plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of This Student Health Benefit Plan. Benefits saved by This Student Health Benefit Plan due to coordination of benefits saving (credit reserve) are available for payment on future claims during this Plan year. Credit reserve will start over for the next Plan year.

**Right to Receive and Release Needed Information**

Certain facts are needed to apply these coordination of benefits rules. The Claims Administrator has the right to decide which facts are needed. The Claims Administrator may get needed facts from, or give them to, any other organization or person. They do not need to tell, or get the consent of, any person to do this. Each person claiming benefits under This Student Health Benefit Plan must provide any facts needed to pay the claim.

**Facility of Payment**

A payment made under another plan may include an amount that should have been paid under This Student Health Benefit Plan. If this happens, This Student Health Benefit Plan may pay that amount to the organization that made that payment. That amount will then be considered a benefit under This Student Health Benefit Plan. This Student Health Benefit Plan 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.

**Right of Recovery**

If This Student Health Benefit Plan pays more than it should have paid under these coordination of benefit rules, This Student Health Benefit Plan may recover the excess from any of the following:

1. the persons This Student Health Benefit Plan paid or for whom This Plan has paid;

2. insurance companies; and

3. other organizations.

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

This Plan maintains both a right of reimbursement and a separate right of subrogation. As an express condition of your participation in this Plan, you agree that the Plan has the subrogation rights and reimbursement rights explained below.

The Plan’s Right of Subrogation

If you or your dependents receive benefits under this Plan arising out of an illness or injury for which a responsible party is or may be liable, this Plan shall be subrogated to your claims and/or your dependents’ claims against the responsible party.

Obligation to Reimburse the Plan

You are obligated to reimburse the Plan in accordance with this provision if the Plan pays any benefits and you, or your dependent(s), heirs, guardians, executors, trustees, or other representatives recover compensation or receive payment related in any manner to an illness, accident or condition, regardless of how characterized, from a responsible party, a responsible party’s insurer or your own (first party) insurer. You must reimburse the Plan for 100 percent of benefits paid by the Plan before you or your dependents, including minors, are entitled to keep or benefit by any payment, regardless of whether you or your dependent has been fully compensated and regardless of whether medical or dental expenses are itemized in a settlement agreement, award or verdict.

You are also obligated to reimburse the Plan from amounts you receive as compensation or other payments as a result of settlements or judgments, including amounts designated as compensation for pain and suffering, non-economic damages and/or general damages. The Plan is entitled to recover from any plan, person, entity, insurer (first party or third party), and/or insurance policy (including no-fault automobile insurance, an uninsured motorist’s plan, a homeowner’s plan, a renter’s plan, or a liability plan) that is or may be liable for:

1. the accident, injury, sickness, or condition that resulted in benefits being paid under the Plan; and/or
2. the medical, dental, and other expenses incurred by you or your dependents for which benefits are paid or will be paid under the Plan.

Until the Plan has been fully reimbursed, all payments received by you, your dependents, heirs, guardians, executors, trustees, attorneys or other representatives in relation to a judgment or settlement of any claim of yours or of your dependent(s) that arises from the same event as to which payment by the Plan is related shall be held by the recipient in constructive trust for the satisfaction of the Plan’s subrogation and/or reimbursement claims.

Complying with these obligations to reimburse the Plan is a condition of your continued coverage and the continued coverage of your dependents.

Duty to Cooperate

You, your dependents, your attorneys or other representatives must cooperate to secure enforcement of these subrogation and reimbursement rights. This means you must take no action – including, but not limited to, settlement of any claim – that prejudices or may prejudice these subrogation or reimbursement rights. As soon as you become aware of any claims for which the Plan is or may be entitled to assert subrogation and reimbursement rights, you must inform the Plan by providing written notification to the Claims Administrator of:

1. the potential or actual claims that you and your dependents have or may have;
2. the identity of any and all parties who are or may be liable; and
3. the date and nature of the accident, injury, sickness or condition for which the Plan has or will pay benefits and for which it may be entitled to subrogate or be reimbursed.
You and your dependents must provide this information as soon as possible, and in any event, before the earlier of the date on which you, your dependents, your attorneys or other representatives:

1. agree to any settlement or compromise of such claims; or
2. bring a legal action against any other party.

You have a continuing obligation to notify the Claims Administrator of information about your efforts or your dependents’ efforts to recover compensation.

In addition, as part of your duty to cooperate, you and your dependents must complete and sign all forms and papers, including a Reimbursement Agreement, as required by the Plan and provide any other information required by the Plan. A violation of the reimbursement agreement is considered a violation of the terms of the Plan.

The Plan may take such action as may be necessary and appropriate to preserve its rights, including bringing suit in your name or intervening in any lawsuit involving you or your dependent(s) following injury. The Plan may require you to assign your rights of recovery to the extent of benefits provided under the Plan. The Plan may initiate any suit against you or your dependent(s) or your legal representatives to enforce the terms of this Plan. The Plan may commence a court proceeding with respect to this provision in any court of competent jurisdiction that the Plan may elect.

**Attorneys’ Fees and Other Expenses You Incur**

The Plan will not be responsible for any attorneys’ fees or costs incurred by you or your dependents in connection with any claim or lawsuit against any party, unless, prior to incurring such fees or costs, the Plan in the exercise of its sole and complete discretion has agreed in writing to pay all or some portion of fees or costs. The common fund doctrine or attorneys’ fund doctrine shall not govern the allocation of attorney’s fees incurred by you or your dependents in connection with any claim or lawsuit against any other party and no portion of such fees or costs shall be an offset against the Plan’s right to reimbursement without the express written consent of the Claims Administrator.

The Plan Administrator may delegate any or all functions or decisions it may have under this Reimbursement and Subrogation section to the Claims Administrator.

**What May Happen to Your Future Benefits**

If you or your dependent(s) obtain a settlement, judgment, or other recovery from any person or entity, including your own automobile or liability carrier, without first reimbursing the Plan, the Plan in the exercise of its sole and complete discretion, may determine that you, your dependents, your attorneys or other representatives have failed to cooperate with the Plan’s subrogation and reimbursement efforts. If the Plan determines that you have failed to cooperate the Plan may decline to pay for any additional care or treatment for you or your dependent(s) until the Plan is reimbursed in accordance with the Plan terms or until the additional care or treatment exceeds any amounts that you or your dependent(s) recover. This right to offset will not be limited to benefits for the insured person or to treatment related to the injury, but will apply to all benefits otherwise payable under the Plan for you and your dependents.

**Interpretation**

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.
Student Health Benefit Plan Administration

Student Health Benefit Plan Administrator

The general administration of the Student Health Benefit Plan and the duty to carry out its provisions is vested in the University of Minnesota, Office of Student Health Benefits. The Office of Student Health Benefits will perform such duties on behalf of the University, provided it may delegate such duty or any portion thereof to a named person, including employees and agents of the University, and may from time to time revoke such authority and delegate it to another person. Any delegation of responsibility must be in writing and accepted by the designated person. Notwithstanding any designation or delegation of final authority with respect to claims, the Student Health Benefit Plan Administrator generally has final authority to administer the Plan.

Powers and Duties of the Student Health Benefit Plan Administrator

The Student Health Benefit Plan Administrator will have the authority to control and manage the operation and administration of the Plan. This will include all rights and powers necessary or convenient to carry out its functions as Plan Administrator. Without limiting that general authority, the Plan Administrator will have the express authority to:

1. construe and interpret the provisions of the Plan and decide all questions of eligibility.
2. prescribe forms, procedures, policies, and rules to be followed by you and other persons claiming benefits under the Plan;
3. prepare and distribute information to you explaining the Plan;
4. receive from you and any other parties the necessary information for the proper administration of eligibility requirements under the Plan;
5. receive, review, and maintain reports of the financial condition and receipts and disbursements of the Plan; and
6. to retain such actuaries, accountants, consultants, third party administration service providers, legal counsel, or other specialists, as it may deem appropriate or necessary for the effective administration of the Plan.

Actions of the Student Health Benefit Plan Administrator

The Student Health Benefit Plan Administrator may adopt such rules as it deems necessary, desirable, or appropriate. All determinations, interpretations, rules, and decisions of the Student Health Benefit Plan Administrator shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan. All rules and decisions of the Student Health Benefit Plan Administrator will be uniformly and consistently applied so that all individuals who are similarly situated will receive substantially the same treatment.

The Student Health Benefit Plan Administrator may contract with one (1) or more service agents, including the Claims Administrator, to assist in the handling of claims under the Plan and/or to provide advice and assistance in the general administration of the Plan. Such service agent(s) may also be given the authority to make payments of benefits under the Plan on behalf of and subject to the authority of the Student Health Benefit Plan Administrator. Such service agent(s) may also be given the authority to determine claims in accordance with procedures, policies, interpretations, rules, or practices made, adopted, or approved by the Student Health Benefit Plan Administrator.
Termination or Changes to the Student Health Benefit Plan

No agent can legally change the Student Health Benefit Plan or waive any of its terms.

The University reserves the power at any time to terminate, modify or amend, in whole or in part, any or all provisions of the Student Health Benefit Plan. Any amendment to this Student Health Benefit Plan may be effected by a written resolution adopted by the University of Minnesota’s Students Health Benefits Office. The Student Health Benefit Plan Administrator will communicate any adopted changes to the covered persons.

Funding

This Student Health Benefit Plan is funded by contributions from the plan and/or participants. Benefits are paid from the Plan’s general assets. Your contribution towards the cost of coverage under the Student Health Benefit Plan will be determined by the Plan each year and communicated to you prior to the effective date of any change in the cost of coverage.

Controlling Law

Except as they may be subject to federal law, any questions, claims, disputes, or litigation concerning or arising from the Student Health Benefit Plan will be governed by the laws of the State of Minnesota.
XVIII: Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Please share this Notice with your covered spouse or same-sex domestic partner, as well as any other covered dependents. This Notice also applies to their medical information.

A. University of Minnesota-Sponsored Student Health Plans Covered by this Notice

This notice describes the practices of the following group health plans (collectively, the “Plan”) and will apply to you to the extent you participate in these plans. If you participate in other plans, you may receive additional notices: Student Health Benefit Plan, Academic Health Center Student Health Benefit Plan

B. Your Protected Health Information

This Notice describes your rights concerning your protected health information (“PHI”) and how the Group Health Plan may use and disclose that information. Your PHI is individually identifiable information about your past, present, or future health or medical condition, health care services provided to you, or the payment for healthcare services. Federal law including the Health Insurance Portability and Accountability Act of 1996 (“HIPAA) requires the Group Health Plan to provide you with this Notice. If you would like to receive this Notice in another language or format, please use the Contact Information at the end of this Notice to contact us for assistance.

C. How the Group Health Plan Uses and Discloses your PHI

The Group Health Plan may use and disclose your PHI:

- **For Treatment** or the coordination of your care. For example, we may disclose information about your medical providers to emergency physicians to help them obtain information that will help in providing medical care to you.

- **For Payment** purposes, such as determining your eligibility for benefits, facilitating payment for services you receive, and coordinating benefits with other plans you may have. For example, we may share your PHI with third party administrators we hire to process claims and provider other administrative services.

- **For Health Care Operations** necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, the Group Health Plan might suggest a disease management or wellness program that could help improve your health, or we may analyze data to determine how to improve services. Although our plan administrators are independent organizations, contracted separately with the University to safeguard your PHI, they may share PHI for the treatment, health care, and payment operations described in this notice.

- **To the Plan Sponsor**, the University of Minnesota, in order to provide summary health information and enrollment and disenrollment information. In addition, provided that the University of Minnesota as the Plan Sponsor agrees, as required by federal law, to certain restrictions on its use and disclosure of any information we share, we may share other health information with the Plan Sponsor for purposes of plan administration.
● To the Health Plan Components within the Group Health Plan in order to facilitate claims payment and certain health care operations of the other plans.

● To Persons Involved With Your Care or those who help pay for your care (such as a family member) when you are incapacitated, in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interest.

● To Organizations Referred to as Business Associates that perform functions on our behalf or provide us with services, if the information is necessary for such functions or services. For example, we periodically retain an organization to audit our Plan administrators, to assure we are receiving high quality services. Such an auditing organization and any of our other business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

● For Plan Evaluation, determining plan rates, underwriting, or making decisions about enhancements and modifications for future plans and coverage. We do not use and are not permitted to use any PHI that is genetic information for underwriting purposes.

● For Public Health Activities such as reporting or preventing disease outbreaks.

● For Reporting Victims of Abuse, Neglect, or Domestic Violence to government authorities that are authorized by law to receive such information, including a social service or protective service agency.

● For Health Oversight Activities to a health oversight agency for activities authorized by law, such as licensure, governmental audits, and fraud and abuse investigations.

● For Judicial or Administrative Proceedings such as in response to a court order, subpoena, discovery request, or other lawful process.

● For Law Enforcement Purposes such as responding to requests from administrative agencies, responding to requests to locate missing persons, reporting criminal activity, or providing information about victims of crime.

● To Provide Information Regarding Decedents to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

● For Organ Procurement Purposes to entities that handle procurement, banking, or transplantation of organs, eyes, or tissue to facilitate donation and transplantation.

● For Research Purposes such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets applicable privacy law requirements.

● To Avoid a Serious Threat to Health or Safety to you, another person, or the public. For example, we may disclose information to public health agencies or law enforcement authorities in the event of an emergency or natural disaster.

● For Specialized Government Functions such as national security and intelligence activities, protective services for the President of the United States and others, and military and veteran activities (if you are a member of the Armed Forces). If you are an inmate at a correctional institution, we may use or disclose your PHI to provide health care to you or to protect your health and safety or that of others or the security of the correctional institution.
● **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers’ compensation laws that govern job-related injuries or illness.

The Group Health Plan will not use or disclose your PHI without your written authorization:

● **For marketing purposes**, unless the marketing is in the form of a face-to-face interaction with you (such as at a University health and benefits fair) or involves providing you with a gift of nominal value (such as mailing you a calendar highlighting certain dates related to your Wellness Program or health plan coverage).

● **As part of a sale to a third party**, unless the transaction is specifically permitted under HIPAA, such as the sale of an entire business operation.

● **Where your PHI is psychotherapy notes**, unless the use and disclosure is required by law, is at issue in a legal action brought by you, is related to treatment, payment, or healthcare operations, or certain other limited circumstances such as oversight of the provider who treated you.

● **For any other purpose** not identified in this Notice.

If you give us authorization to release your PHI, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To revoke your authorization, send a written request to the address listed in the Contact Information section included in this Notice.

D. Your Rights Concerning your PHI:

● **You have the right to ask to restrict** uses or disclosures of your PHI for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. Any such requests must be in writing and must state the specific restriction you are requesting. Submit your request in writing to the address listed in the Contact Information section of this Notice. Please note that while we will try to honor your request, we are not required to agree to any restriction.

● **You have the right to ask to receive confidential communications** of your PHI in a certain manner or at a certain place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where you indicate that a disclosure of all or part of your PHI could endanger you. Your request must be made in writing or via email using the information listed in the Contact Information section of this Notice.

● **You have the right to inspect and obtain a copy** of your PHI that is maintained in a “designated record set.” The designated record set consists of records used in making payment, claims determinations, medical management, and other decisions. You must make a written request to inspect and copy your PHI. Mail your request to the address listed in the Contact Information section included in this Notice. We may charge a reasonable fee for any copies. In certain limited circumstances, we may deny your request to inspect and copy your PHI. If we deny your request, you have the right to have the denial reviewed. If we maintain an electronic health record containing your health information, when and if we are required by law, you will have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.
You have the right to ask to amend PHI we maintain about you if you believe the information is wrong or incomplete. Your request must be in writing and must provide the reasons for the requested amendment. Mail your request to the address listed in the Contact Information section of this Notice. If we deny your request, you may have a statement of your disagreement added to your health information.

You have the right to receive an accounting of certain disclosures of your PHI made by the Group Health Plan during the six years prior to your request. This accounting will not include disclosures of information made: (a) for treatment, payment, and health care operations purposes; (b) to you or pursuant to your authorization; (c) to correctional institutions or law enforcement officials; and (d) certain other disclosures for which federal law does not require us to provide an accounting. Your request must be in writing and mailed to the address listed in the Contact Information section of this Notice. If you make multiple requests for an accounting of disclosures in any 12 month period, we may charge you a reasonable fee to provide the accounting.

You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Submit your request in writing by mail or email using the information listed in the Contact Information section of this Notice.

E. Complaints

You may file a complaint if you believe your privacy rights have been violated. Use the mailing address, email address, or phone number listed in the Contact Information section of this Notice to file your complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. We will not take any action against you for filing a complaint.

F. The Group Health Plan’s Duties Concerning your PHI

The Group Health Plan is required to maintain the privacy of your protected health information, provide you this Notice of its legal duties and privacy practices, follow the terms of the Notice currently in effect, and provide you with notice in the event of a breach of any of your unsecured PHI. The Group Health Plan reserves the right to change the terms of this Notice at any time. Any new Notice will be effective for all PHI that the Group Health Plan then maintains, as well as any PHI the Group Health Plan later receives or creates. Unless otherwise required by law, any new Notice will be effective as of its effective date.

G. Contact Information

If you have questions or need further information, please contact:

Office of Student Health Benefits
University of Minnesota
410 Church Street S.E., Room N323
Minneapolis, MN  55455

612-624-0627 or 1-800-232-9017
umshbo@umn.edu

Effective Date of this Notice: September 23, 2013
GLOSSARY OF COMMON TERMS

Refer to the Benefit Chart for specific benefit and payment information.

90dayRx  Participating 90dayRx Retail Pharmacies and Mail Service Pharmacy used for the dispensing of a 90-day supply of long-term prescription drug refills.

Admission  A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.

Advanced practice nurses  Licensed registered nurses who have gained additional knowledge and skills through an organized program of study and clinical experience that meets the criteria for advanced practice established by the professional nursing organization having the authority to certify the registered nurse in the advanced nursing practice. Advanced practice nurses include clinical nurse specialists (C.N.S.), nurse practitioners (N.P.), certified registered nurse anesthetists (C.R.N.A.), and certified nurse midwives (C.N.M.).

Allowed amount  The amount upon which payment is based for a given covered service for a specific provider. The allowed amount may vary from one provider to another for the same service. All benefits are based on the allowed amount, except as specified in the Benefit Chart.

The Allowed Amount for Participating Providers

For Participating Providers, the allowed amount is the negotiated amount of payment that the Participating Provider has agreed to accept as full payment for a covered service at the time your claim is processed. The Claims Administrator periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at Participating Providers as a result of expected settlements or other factors. The negotiated amount of payment with Participating Providers for certain covered services may not be based on a specified charge for each service, and the Claims Administrator uses a reasonable allowance to establish a per service allowed amount for such covered services.

Through settlements or other special arrangements with Participating Providers the Claims Administrator may prospectively or subsequently pay a different amount to a Participating Provider. Such payments will not affect or cause any change in the amount you paid at the time your claim was processed.

Qualifications Applicable to All Nonparticipating Providers

In determining the allowed amount for Nonparticipating Providers, the Claims Administrator makes no representations that this allowed amount is a usual, customary, or reasonable charge from a provider. The allowed amount is the amount that the Plan will pay for a covered service. The Plan will pay this amount to you. The determination of the allowed amount is subject to all of the Claims Administrator’s business rules as defined in the Claims Administrator Provider Policy and Procedure Manual. As a result, the Claims Administrator may bundle services or take multiple procedure discounts and/or reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.
The Allowed Amount for Nonparticipating Providers in Minnesota

For Nonparticipating Provider services within Minnesota, except those described under Special Circumstances below, the allowed amount will be an amount based upon one of the following payment options to be determined by the Claims Administrator at its discretion: (1) a Minnesota Nonparticipating Provider fee schedule posted at the Claims Administrator's website; (2) a percentage of the published Medicare allowed charge for the same or similar service; (3) a percentage of billed charges; or (4) pricing using a nationwide provider reimbursement database. The payment option selected by the Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option.

The Allowed Amount for All Nonparticipating Provider Services Outside Minnesota

For Nonparticipating Provider services outside of Minnesota, except those described under Special Circumstances below, the allowed amount will be an amount based upon one of the following payment options, to be determined by the Claims Administrator at its discretion: (1) a Minnesota Nonparticipating Provider fee schedule posted at the Claims Administrator's website; (2) a percentage of the published Medicare allowed charge for the same or similar service; (3) a percentage of billed charges; (4) pricing determined by the Host Blue plan; or (5) pricing using a nationwide provider reimbursement database. The payment option selected by the Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option.

Special Circumstances

When you receive care from certain nonparticipating professionals at a participating facility such as a hospital, outpatient facility, or emergency room, the reimbursement to the nonparticipating professional may include some of the costs that you would otherwise be required to pay (e.g., the difference between the allowed amount and the provider’s billed charge). This reimbursement applies when nonparticipating professionals are hospital-based and needed to provide immediate medical or surgical care and you do not have the opportunity to select the provider of care. The extent of reimbursement in these circumstances may also be subject to federal law.

If you have questions about the benefits available for services to be provided by a Nonparticipating Provider, you will need to speak with your provider and you may call the Claims Administrator Customer Service at the telephone number on the back of your member ID card for more information.

Artificial Insemination (AI)

The introduction of semen from a donor (which may have been preserved as a specimen), into a woman’s vagina, cervical canal, or uterus by means other than sexual intercourse.

Assisted Reproductive Technologies (ART)

Fertility treatments in which both eggs and sperm are handled. In general, ART procedures involve surgically removing eggs from a woman’s ovaries, combining them with sperm in the laboratory, and returning them to the woman’s body or donating them to another woman. Such treatments do not include procedures in which only sperm are handled (i.e., intrauterine insemination (IUI), or artificial insemination (AI)), or procedures in which a woman takes medicine only to stimulate egg production without the intention of having eggs retrieved.
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending health care professional</td>
<td>A health care professional with primary responsibility for the care provided to a sick or injured person.</td>
</tr>
<tr>
<td>Average semiprivate room rate</td>
<td>The average rate charged for semiprivate rooms. If the provider has no semiprivate rooms, the Claims Administrator uses the average semiprivate room rate for payment of the claim.</td>
</tr>
<tr>
<td>BlueCard Network Provider</td>
<td>Providers who have entered into a specific network contract with the local Blue Cross and/or Blue Shield Plan outside of Minnesota.</td>
</tr>
<tr>
<td>BlueCard Program</td>
<td>A national Blue Cross and Blue Shield program in which employees and dependents can receive health plan benefits while traveling or living outside the state of Minnesota. Employees and dependents must show their membership ID to secure benefits.</td>
</tr>
<tr>
<td>Care/case management plan</td>
<td>A plan for health care services developed for a specific patient by a care/case manager after an assessment of the patient’s condition in collaboration with the patient and the patient’s health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain or achieve optimal health status.</td>
</tr>
<tr>
<td>Claim</td>
<td>A written submission from your provider (or you when you use Nonparticipating Providers) to the Claims Administrator. Most claims are submitted electronically. The claim tells the Claims Administrator what services the provider delivered to you. In some cases, the Claims Administrator may require additional information from the provider or you before a determination can be made. When this occurs, work with your provider to return the information to the Claims Administrator promptly. If the provider delivered a service that is not covered, the claim will be denied, meaning no payment is allowed. Providers are required to use certain codes to explain the care they give you. The provider’s medical records must support the codes being used. The Claims Administrator may not change the codes a provider uses on a claim. If you believe your provider has not used the right codes on your claim, you will need to contact your provider.</td>
</tr>
<tr>
<td>Claims Administrator</td>
<td>Blue Cross and Blue Shield of Minnesota (Blue Cross).</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copays and until you reach your out-of-pocket and/or intermediate maximum. For covered services from In-Network and Extended Network (if applicable) Providers, coinsurance is calculated based on the lesser of the allowed amount or the In-Network and Extended Network (if applicable) Provider's billed charge. Because payment amounts are negotiated with In-Network and Extended Network (if applicable) Providers to achieve overall lower costs, the allowed amount for In-Network and Extended Network (if applicable) Providers is generally, but not always, lower than the billed charge. However, the amount used to calculate your coinsurance will not exceed the billed charge. When your coinsurance is calculated on the billed charge rather than the allowed amount for In-Network and Extended Network (if applicable) Providers, the percentage of the allowed amount paid by the Claims Administrator will be greater than the stated percentage. For covered services from Nonparticipating Providers, coinsurance is calculated based on the allowed amount. In addition, you are responsible for any excess charge over the allowed amount.</td>
</tr>
</tbody>
</table>
Your coinsurance and deductible amount will be based on the negotiated payment amount the Claims Administrator has established with the provider or the provider’s charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.

Coinsurance Example:

You are responsible for payment of any applicable coinsurance amounts for covered services. The following is an example of how coinsurance would work for a typical claim:

For instance, when the Claims Administrator pays 80% of the allowed amount for a covered service, you are responsible for the coinsurance, which is 20% of the allowed amount. In addition, you would be responsible for any excess charge over the Claims Administrator’s allowed amount when a Nonparticipating Provider is used. For example, if a Nonparticipating Provider ordinarily charges $100 for a service, but the Claims Administrator’s allowed amount is $95, the Claims Administrator will pay 80% of the allowed amount ($76). You must pay the 20% coinsurance on the Claims Administrator’s allowed amount ($19), plus the difference between the billed charge and the allowed amount ($5), for a total responsibility of $24.

Remember, if In-Network and Extended Network (if applicable) Providers are used, your share of the covered charges (after meeting any deductibles) is limited to the stated coinsurance amounts based on the Claims Administrator’s allowed amount. If Nonparticipating Providers are used, your out-of-pocket costs will be higher as shown in the example above.

**Compounded drug**

A prescription where two or more drugs are mixed together. One of these must be a Federal legend drug. The end product must not be available in an equivalent commercial form. A prescription will not be considered a compound if only water or sodium chloride solution are added to the active ingredient.

**Comprehensive pain management program**

A multidisciplinary program including, at a minimum, the following components:

1. a comprehensive physical and psychological evaluation;
2. physical/occupation therapies;
3. a multidisciplinary treatment plan; and
4. a method to report clinical outcomes.

**Copay**

The dollar amount you must pay for certain covered services. The Benefit Chart lists the copays and services that require copays.

A negotiated payment amount with the provider for a service requiring a copay will not change the dollar amount of the copay.

**Cosmetic services**

Surgery and other services performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function.

**Covered services**

A health service or supply that is eligible for benefits when performed and billed by an eligible provider. You incur a charge on the date a service is received or a supply or a drug is purchased.
Custodial care

Services to assist in activities of daily living, such as giving medicine that can usually be taken without help, preparing special foods, helping someone walk, get in and out of bed, dress, eat, bathe and use the toilet. These services do not seek to cure, are performed regularly as part of a routine or schedule, and do not need to be provided directly or indirectly by a health care professional.

Cycle

One (1) partial or complete fertilization attempt extending through the implantation phase only.

Day treatment

Behavioral health services that may include a combination of group and individual therapy or counseling for a minimum of three (3) hours per day, three (3) to five (5) days per week.

Dependent

Your spouse, child to the dependent child age limit specified in the Eligibility section, child whom you or your spouse have adopted or been appointed legal guardian to the dependent child age limit specified in the Eligibility section, disabled dependent or dependent child as defined in the Eligibility section, or any other person whom state or federal law requires be treated as a dependent under this Plan.

Drug therapy supply

A disposable article intended for use in administering or monitoring the therapeutic effect of a drug.

Durable medical equipment

Medical equipment prescribed by a physician that meets each of the following requirements:

1. able to withstand repeated use;
2. used primarily for a medical purpose;
3. generally not useful in the absence of illness or injury;
4. determined to be reasonable and necessary; and
5. represents the most cost-effective alternative.

E-Visit

An online evaluation and management service provided by a physician using the internet or similar secure communications network to communicate with an established patient.

Eligible credits

Eligible credits are credits registered for that contribute towards the total count under the enrollment guidelines for being assessed mandatory Student Services Fee and also require proof of health insurance or result in a charge for the Student Health Benefit Plan.

Emergency hold

A process defined in Minnesota law that allows a provider to place a person who is considered to be a danger to themselves or others, in a hospital involuntarily for up to 72 hours, excluding Saturdays, Sundays, and legal holidays, to allow for evaluation and treatment of mental health and/or substance abuse issues.

Enrollment date

The first day of coverage, for each academic semester or academic summer session.
Extended hours skilled nursing care

Also referred to as private-duty nursing care, is complex nursing care services provided in a member’s home for greater than four (4) hours in a 24-hour period.

Extended hours skilled nursing care services provide complex, direct, skilled nursing care to develop caregiver competencies through training and education to optimize the member’s health status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.

Facility

A provider that is a hospital, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed under state law, in the state in which it is located to provide the health services billed by that facility. Facility may also include a licensed home infusion therapy provider, freestanding ambulatory surgical center, home health agency, or freestanding birthing center when services are billed on a facility claim.

Family therapy

Behavioral health therapy intended to treat an individual, diagnosed with a mental health condition, within the context of family relationships.

Foot orthoses

Appliances or devices used to stabilize, support, align, or immobilize the foot in order to prevent deformity, protect against injury, or assist with function. Foot orthoses generally refer to orthopedic shoes, and devices or inserts that are placed in shoes including heel wedges and arch supports. Foot orthoses are used to decrease pain, increase function, correct some foot deformities, and provide shock absorption to the foot. Orthoses can be classified as pre-fabricated or custom made. A pre-fabricated orthosis is manufactured in quantity and not designed for a specific patient. A custom-fitted orthosis is specifically made for an individual patient.

Freestanding ambulatory surgical center

A provider who facilitates medical and surgical services to sick and injured persons on an outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.) and/or registered nurses (R.N.). A freestanding ambulatory surgical center is not part of a hospital, clinic, doctor’s office, or other health care professional’s office.

Group home

A supportive living arrangement offering a combination of in-house and community resource services. The emphasis is on securing community resources for most daily programming and employment.

Group therapy

Behavioral health therapy conducted with multiple patients.

Halfway house

Specialized residences for individuals who no longer require the complete facilities of a hospital or institution but are not yet prepared to return to independent living.

Health care professional

A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, speech and occupational therapists, licensed nutritionists, licensed registered dieticians, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.
<table>
<thead>
<tr>
<th><strong>Home health agency</strong></th>
<th>A Medicare approved or other preapproved facility that sends health professionals and home health aides into a person’s home to provide health services.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice care</strong></td>
<td>A coordinated set of services provided at home or in an institutional setting for covered individuals suffering from a terminal disease or condition.</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td>A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.</td>
</tr>
<tr>
<td><strong>Host Blue</strong></td>
<td>A Blue Cross and/or Blue Shield organization outside of Minnesota that has contractual relationships with Participating Providers in its designated service area that require such Participating Providers to provide services to members of other Blue Cross and/or Blue Shield organizations.</td>
</tr>
<tr>
<td><strong>Illness</strong></td>
<td>A sickness, injury, pregnancy, mental illness, substance abuse, or condition involving a physical disorder.</td>
</tr>
<tr>
<td><strong>In-Network Provider</strong></td>
<td>A provider that has entered into a specific network contract with the Claims Administrator or with the local Blue Cross and/or Blue Shield Plan. Refer to the Benefit Chart and Coverage Information sections for network details.</td>
</tr>
<tr>
<td><strong>Infertility testing</strong></td>
<td>Services associated with establishing the underlying medical condition or cause of infertility. This may include the evaluation of female factors (i.e., ovulatory, tubal, or uterine function), male factors (i.e., semen analysis or urological testing) or both and involves physical examination, laboratory studies and diagnostic testing performed solely to rule out causes of infertility or establish an infertility diagnosis.</td>
</tr>
<tr>
<td><strong>Intensive Outpatient Programs (IOP)</strong></td>
<td>A behavioral health care service setting that provides structured multidisciplinary diagnostic and therapeutic services. IOPs operate at least three (3) hours per day, three (3) days per week. Substance Abuse treatment is typically provided in an IOP setting. Some IOPs provide treatment for mental health disorders.</td>
</tr>
<tr>
<td><strong>Intermittent skilled nursing care</strong></td>
<td>A visit by an employee or employees of an approved home health care agency of up to a total of four (4) hours in a 24 hour period.</td>
</tr>
<tr>
<td><strong>Intrauterine Insemination (IUI)</strong></td>
<td>A specific method of artificial insemination in which semen is introduced directly into the uterus.</td>
</tr>
</tbody>
</table>
| **Investigative**       | A drug, device, diagnostic procedure, technology, or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The Claims Administrator bases its decision upon an examination of the following reliable evidence, none of which is determinative in and of itself:  
  1. the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;  
  2. the drug, device, diagnostic procedure, technology, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials (Phase I clinical trials determine the safe dosages of medication for Phase II trials and define acute effects on normal tissue. Phase II clinical trials determine clinical response in a defined patient setting). |
If significant activity is observed in any disease during Phase II, further clinical trials usually study a comparison of the experimental treatment with the standard treatment in Phase III trials. Phase III trials are typically quite large and require many patients to determine if a treatment improves outcomes in a large population of patients;

3. medically reasonable conclusions establishing its safety, effectiveness, or effect on health outcomes have not been established. For purposes of this subparagraph, a drug, device, diagnostic procedure, technology, or medical treatment or procedure shall not be considered investigative if reliable evidence shows that it is safe and effective for the treatment of a particular patient.

Reliable evidence shall also mean consensus opinions and recommendations reported in the relevant medical and scientific literature, peer-reviewed journals, reports of clinical trial committees, or technology assessment bodies, and professional expert consensus opinions of local and national health care providers.

**Lifetime maximum**

The cumulative maximum payable for covered services incurred by you during your lifetime or by each of your dependents during the dependent’s lifetime under all health plans sponsored by the Student Health Benefit Plan Administrator. The lifetime maximum does not include amounts which are your responsibility such as coinsurance, copays, penalties, and other amounts. Refer to the Benefit Chart for specific dollar maximums on certain services.

**Mail service pharmacy**

A pharmacy that dispenses prescription drugs through the U.S. Mail.

**Marital/couples counseling**

Behavioral health care services for the primary purpose of working through relationship issues.

**Marital/couples training**

Services for the primary purpose of relationship enhancements including, but not limited to: premarital education; or marriage/couples retreats; encounters; or seminars.

**Medical emergency**

Medically necessary care which a reasonable layperson believes is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.

**Medically necessary**

Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on creditable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.
Medicare

A federal health insurance program established under Title XVIII of the Social Security Act. Medicare is a program for people age 65 or older; some people with disabilities under age 65; and people with end-stage renal disease. The program includes Part A, Part B and Part D. Part A generally covers some costs of inpatient care in hospitals and skilled nursing facilities. Part B generally covers some costs of physician, medical, and other services. Part D generally covers outpatient prescription drugs defined as those drugs covered under the Medicaid program plus insulin, insulin-related supplies, certain vaccines, and smoking cessation agents. Medicare Parts A, B and D do not pay the entire cost of services and are subject to cost sharing requirements and certain benefit limitations.

Medicare allowed charge

The charge that Medicare would authorize as the cost of a service or supply from a provider that participates in Medicare. The Medicare allowed charge is adjusted by location in the United States according to Geographic Practice Cost Indices (GPCIs) calculated by Medicare. The Medicare allowed charge for covered inpatient care is based upon the Acute Hospital Inpatient Prospective Payment System (PPS). The Medicare allowed charge does not include additional amounts, such as Disproportionate Share Hospital, Direct Graduate Medical Education, outlier amounts or other charges that are not included in the Prospective Payment System amount. Payment for physician services is based solely upon the Medicare Physician Fee Schedule.

The determination of the allowed amount is subject to all Medicare payment rules. As a result, the Claims Administrator may bundle services or take multiple procedure discounts and/or other reductions consistent with Medicare payment procedures resulting from the procedures performed and billed on the claim.

The Medicare allowable charge that is current as of the time the services are provided will be the amount that is used in determining the allowed amount.

Mental health care professional

A psychiatrist, psychologist, licensed independent clinical social worker, marriage and family therapist, nurse practitioner or a clinical nurse specialist licensed for independent practice that provides treatment for mental health disorders.

Mental illness

A mental disorder as defined in the International Classification of Diseases. It does not include alcohol or drug dependence, nondependent abuse of drugs, or developmental disability.

Mobile crisis services

Face-to-face short term, intensive behavioral health care services initiated during a behavioral health crisis or emergency. This service may be provided on-site by a mobile team outside of an inpatient hospital setting or nursing facility. Services can be available 24 hours a day, seven (7) days a week, 365 days per year.

Neuro-psychological examinations

Examinations for diagnosing brain dysfunction or damage and central nervous system disorders or injury. Services may include interviews, consultations and testing to assess neurological function associated with certain behaviors.

Nonparticipating Provider

A provider that has not entered into a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan.

Opioid treatment

Treatment that uses methadone as a maintenance drug to control withdrawal symptoms for opioid addiction.

Out-of-Network Provider

A Participating Provider that is not In-Network; and Nonparticipating Providers.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
</table>
Preferred drug list
A list of prescription drugs and drug therapy supplies used by patients in an ambulatory care setting. Over-the-counter drugs, injectable medications, and drug therapy supplies are not included in your specified preferred drug list unless they are specifically listed.

Prescription drugs
Drugs, including insulin, that are required by federal law to be dispensed only by prescription of a health professional who is authorized by law to prescribe the drug.

Provider
A health care professional licensed, certified or otherwise qualified under state law, in the state in which services are rendered, to provide the health services billed by that provider and a health care facility licensed under state law in the state in which it is located to provide the health services billed by that facility. Provider includes pharmacies, medical supply companies, independent laboratories ambulances, freestanding ambulatory surgical centers, home infusion therapy providers, and also home health agencies.

Qualifying creditable coverage
Health coverage provided through an individual policy, a self-funded or fully-insured group health plan offered by a public or private employer, Medicare, MinnesotaCare, Medical Assistance (Medicaid), General Assistance Medical Care, the Minnesota Comprehensive Health Association (MCHA), TRICARE, Federal Employees Health Benefit Plan (FEHBP), Medical care program of the Indian Health Service of a tribal organization, a state health benefit risk pool, a Peace Corps health plan, Minnesota Employee Insurance Program (MEIP), Public Employee Insurance Program (PEIP), any plan established or maintained by a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan; the Children’s Health Insurance Program (CHIP), or any plan similar to any of the above plans provided in this state or in another state as determined by the Minnesota Commissioners of Commerce or Health.

Reproduction treatment
Treatment to enhance the reproductive ability among patients experiencing infertility, after a confirmed diagnosis of infertility has been established due to either female, male factors or unknown causes. Treatment may involve oral and/or injectable medications, surgery, artificial insemination, assisted reproductive technologies or a combination of these.

Residential behavioral health treatment facility
A facility licensed under state law in the state in which it is located that provides treatment, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, substance abuse or substance addiction. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.

Respite care
Short-term inpatient or home care provided to the patient when necessary to relieve family members or other persons caring for the patient.

Retail health clinic
A clinic located in a retail establishment or worksite. The clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail health clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Retail pharmacy</td>
<td>Any licensed pharmacy that you can physically enter to obtain a prescription drug.</td>
</tr>
<tr>
<td>Services</td>
<td>Health care service, procedures, treatments, durable medical equipment, medical supplies and prescription drugs.</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td>Inadequate enjoyment of or failure to participate in or enjoy sexual activity.</td>
</tr>
<tr>
<td>Skilled care</td>
<td>Services that are medically necessary and provided by a licensed nurse or other licensed health care professional (up to four (4) hours in a 24 hour period). A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed nurse. Services such as tracheotomy suctioning or ventilator monitoring that can be safely and effectively performed by a non-medical person (or self-administered) without direct supervision of a licensed nurse, shall not be regarded as skilled care, whether or not a licensed nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it skilled care when a licensed nurse provides the service. Only the skilled care component of combined services that include non-skilled care are covered under the Plan.</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>A Medicare approved facility that provides skilled transitional care, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), after a hospital stay. A skilled nursing facility provides 24-hour-a-day professional registered nursing (R.N.) services.</td>
</tr>
<tr>
<td>Student Health Benefit Plan</td>
<td>The Student Health Benefit Plan of benefits established by the Student Health Benefit Plan Administrator.</td>
</tr>
<tr>
<td>Student Health Benefit Plan Administrator</td>
<td>University of Minnesota; Boynton Health Service, Office of Student Health Benefits.</td>
</tr>
<tr>
<td>Substance abuse and/or addictions</td>
<td>Alcohol, drug dependence or other addictions as defined in the most current edition of the International Classification of Diseases.</td>
</tr>
<tr>
<td>Supervised employees</td>
<td>Health care professional employed by a doctor of medicine, osteopathy, chiropractic, or dental surgery or Minnesota Rule 29 behavioral health treatment facilities licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S. or mental health professional must be physically present and immediately available in the same office suite more than 50 percent of each day when the employed health care professional is providing services. Independent contractors are not eligible.</td>
</tr>
<tr>
<td>Supply</td>
<td>Equipment that must be medically necessary for the medical treatment or diagnosis of an illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year.</td>
</tr>
<tr>
<td></td>
<td>Supplies do not include such things as:</td>
</tr>
<tr>
<td></td>
<td>1. alcohol swabs;</td>
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<tr>
<td></td>
<td>2. cotton balls;</td>
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<td>3. incontinence liners/pads;</td>
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<td>4. Q-tips;</td>
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<td></td>
<td>5. adhesives; or</td>
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<td></td>
<td>6. informational materials.</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td><strong>Surrogate pregnancy</strong></td>
<td>An arrangement whereby a woman who is not covered under this Plan becomes pregnant for the purpose of gestating and giving birth to a child for others to raise.</td>
</tr>
<tr>
<td><strong>Terminally ill patient</strong></td>
<td>An individual who has a life expectancy of six (6) months or less, as certified by the person’s primary physician.</td>
</tr>
<tr>
<td><strong>Therapeutic camps</strong></td>
<td>A structured recreational program of behavioral health treatment and care provided by an enrolled family community support services provider that is licensed as a day program. The camps are accredited as a camp by the American Camping Association.</td>
</tr>
<tr>
<td><strong>Therapeutic day care (pre-school)</strong></td>
<td>A licensed program that provides behavioral health care services to a child who is at least 33 months old but who has not yet attended the first day of kindergarten. The therapeutic components of a pre-school program must be available at least one (1) day a week for a minimum two (2)-hour time block. Services may include individual or group psychotherapy and a combination of the following activities: recreational therapy, socialization therapy and independent living skills therapy.</td>
</tr>
<tr>
<td><strong>Therapeutic support of foster care</strong></td>
<td>Behavioral health training, support services, and clinical supervision provided to foster families caring for children with severe emotional disturbance. The intended purpose is to provide a therapeutic family environment and support for the child’s improved functioning.</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>The management and care of a patient for the purpose of combating an illness. Treatment includes medical care surgical care, diagnostic evaluation, giving medical advice, and monitoring and taking medication.</td>
</tr>
<tr>
<td><strong>UMC Health Service Benefit</strong></td>
<td>The highest benefit level provided to students covered under this Student Health Benefit Plan during the time that they are paying the Student Services Fee.</td>
</tr>
</tbody>
</table>