Residents and Fellows
Basic Plus Option

2010 -2011
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</tbody>
</table>
Summary of Benefits (SB) Effective Date: The later of May 1, 2010 and the Covered Person's effective date of coverage under the Plan.

HealthPartners Open Access Choice
Schedule of Benefits

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

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

Coverage may vary according to your network or provider selection.

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

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

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

The usual and customary charge is the maximum amount allowed which the Plan considers in the calculation of payment of charges incurred for certain covered services. It is consistent with the charge of other providers of a given service or item in the same region.

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

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

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

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

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

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

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

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

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

You are responsible to keep track of the out-of-pocket expenses. Contact HealthPartners Member Services department for assistance in determining the amount paid by the Covered Person for specific eligible services received. Claims for reimbursement under the out-of-pocket limit provisions are subject to the same time limits and provisions described under the “Claims Procedures” section of the SB.
<table>
<thead>
<tr>
<th>Benefits Description</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Plan Year Deductible</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Family Plan Year Deductible</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>The deductibles under the Network Benefits and the Out-of-Network Benefits are combined.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Plan Year Out-of-Pocket Limit for Prescription Drugs</td>
<td>$300</td>
<td>$300</td>
</tr>
<tr>
<td>Family Plan Year Out-of-Pocket Limit for Prescription Drugs</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>The Out-of-Pocket Limit for prescription drugs does not include prescription drugs administered during treatment in a hospital, drugs for the treatment of growth deficiency, drugs for the treatment of infertility, special dietary treatment for Phenylketonuria (PKU), injections administered in a doctor's office, durable medical equipment, diabetic supplies and amino acid based elemental formula. These listed services will apply toward the out of pocket limits for all other services, shown below.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Plan Year Out-of-Pocket Limit for all other services</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Family Plan Year Out-of-Pocket Limit for all other services</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>The out-of-pocket limits under the Network Benefits and the Out-of-Network Benefits are combined.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility Services Lifetime Maximum Benefit (including drugs for the treatment of infertility)</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>The Infertility Services Lifetime Maximum Benefit is combined for the Network Benefits and the Out-of-Network Benefits. Any benefits applied to the Infertility Services Lifetime Maximum Benefit shown above will also apply towards the Lifetime Maximum Benefit described below.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>$5,000,000</td>
<td>$5,000,000</td>
</tr>
<tr>
<td>The Lifetime Maximum Benefit is combined for the Network Benefits and the Out-of-Network Benefits.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

**YOU ARE REQUIRED TO GET PRE-CERTIFICATION BEFORE USING CERTAIN OUT-OF-NETWORK SERVICES. SEE I.F. "CARECHECK®" IN THIS SB FOR SPECIFIC INFORMATION ABOUT PRE-CERTIFICATION.**

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. ACUPUNCTURE</strong></td>
<td>No coverage.</td>
</tr>
<tr>
<td>$25 copayment and 100% thereafter for the office visit charge. Deductible does not apply.</td>
<td>90% of the charges incurred for all other eligible services. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>90% of the charges incurred for all other eligible services. Deductible must first be satisfied.</td>
<td></td>
</tr>
</tbody>
</table>

| **B. AMBULANCE AND MEDICAL TRANSPORTATION** | No coverage. |
| 90% of the charges incurred. Deductible must first be satisfied. | 90% of the charges incurred. Deductible must first be satisfied. |
|  |

| **C. BEHAVIORAL HEALTH SERVICES** | No coverage. |
| Mental Health Services | 90% of the charges incurred. Deductible must first be satisfied. |

| a. Outpatient Services, including group therapy, day treatment and intensive outpatient services | No coverage. |
| For services provided during an office visit | 90% of the charges incurred. Deductible must first be satisfied. |
| $25 copayment and 100% thereafter for the office visit charge. Deductible does not apply. | 90% of the charges incurred. Deductible must first be satisfied. |
| 90% of the charges incurred for all other eligible services. Deductible must first be satisfied. |  |
| **For family therapy, only one copayment will be charged, regardless of the number of family members primarily involved in the therapy.** |  |

| For services provided in an outpatient hospital facility | 90% of the charges incurred. Deductible must first be satisfied. |
| 90% of the charges incurred. Deductible must first be satisfied. |  |

| b. Inpatient Services, including psychiatric treatment for emotionally handicapped children | No coverage. |
| See Network Inpatient Hospital Services Benefit. | See Out-of-Network Inpatient Hospital Services Benefit. |
| Limited to a 365 day maximum per period of confinement, subject to the combined day limit. | Limited to a 365 day maximum per period of confinement, subject to the combined day limit. |
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

**Chemical Health Services**

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a. Outpatient Services, including day treatment and intensive outpatient services</strong></td>
<td></td>
</tr>
<tr>
<td>For services provided during an office visit</td>
<td></td>
</tr>
<tr>
<td>$25 copayment and 100% thereafter for the office visit charge. Deductible does not apply.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>90% of the charges incurred for all other eligible services. Deductible must first be satisfied.</td>
<td></td>
</tr>
<tr>
<td><em>For family therapy, only one copayment will be charged, regardless of the number of family members primarily involved in the therapy.</em></td>
<td></td>
</tr>
<tr>
<td>For services provided in an outpatient hospital facility</td>
<td></td>
</tr>
<tr>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>The Plan covers supervised lodging at a contracted organization for Covered Persons actively involved in an affiliated licensed chemical dependency day treatment or intensive outpatient program for treatment of alcohol or drug abuse.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>b. Inpatient Services</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>See Network Inpatient Hospital Services Benefit.</td>
<td>See Out-of-Network Inpatient Hospital Services Benefit.</td>
</tr>
<tr>
<td><em>Limited to a 365 day maximum per period of confinement, subject to the combined day limit.</em></td>
<td><em>Limited to a 365 day maximum per period of confinement, subject to the combined day limit.</em></td>
</tr>
</tbody>
</table>

**D. CHIROPRACTIC SERVICES**

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25 copayment and 100% thereafter for the office visit charge. Deductible does not apply.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>90% of the charges incurred for all other eligible services. Deductible must first be satisfied.</td>
<td></td>
</tr>
</tbody>
</table>
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
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<th>E. DENTAL SERVICES</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
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</thead>
<tbody>
<tr>
<td>(See subsection E. Dental Services under Section III. Description of Covered Services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental Dental Services</td>
<td>$25 copayment and 100% thereafter for the office visit charge. Deductible does not apply. 90% of the charges incurred for all other eligible services. Deductible must first be satisfied.</td>
<td>For all accidental dental services, treatment and/or restoration must be initiated within twelve months of the date of the injury. Coverage is limited to the initial course of treatment and/or initial restoration. Services must be provided within twenty-four months of the date of injury to be covered.</td>
</tr>
<tr>
<td>Medical Referral Dental Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Medically Necessary Outpatient Dental Services</td>
<td>$25 copayment and 100% thereafter for the office visit charge. Deductible does not apply. 90% of the charges incurred for all other eligible services. Deductible must first be satisfied.</td>
<td></td>
</tr>
<tr>
<td>b. Medically Necessary Hospitalization and Anesthesia for Dental Care</td>
<td>See Network Inpatient Hospital Services Benefit.</td>
<td>See Out-of-Network Inpatient Hospital Services Benefit.</td>
</tr>
<tr>
<td>c. Medical Complications of Dental Care</td>
<td>$25 copayment and 100% thereafter for the office visit charge. Deductible does not apply. 90% of the charges incurred for all other eligible services. Deductible must first be satisfied.</td>
<td></td>
</tr>
</tbody>
</table>
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
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<tr>
<th>Covered Service</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orthognathic Surgery Benefit</strong></td>
<td>$25 copayment and 100% thereafter for the office visit charge.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>90% of the charges incurred for all other eligible services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deductible must first be satisfied.</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment of Cleft Lip and Cleft Palate of a Dependent Child</strong></td>
<td>$25 copayment and 100% thereafter for the office visit charge.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>90% of the charges incurred for all other eligible services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deductible must first be satisfied.</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD)</strong></td>
<td>$25 copayment and 100% thereafter for the office visit charge.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>90% of the charges incurred for all other eligible services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deductible must first be satisfied.</td>
<td></td>
</tr>
</tbody>
</table>

F. DIAGNOSTIC IMAGING SERVICES

The Plan covers services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)

Associated with covered preventive services (MRI/CT procedures are not considered preventive)

Diagnostic imaging for preventive services is covered at the benefit level shown in the Preventive Services section.

For illness or injury

a. Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) 100% of the charges incurred. Deductible does not apply. 90% of the charges incurred. Deductible must first be satisfied.

b. All other outpatient diagnostic imaging services 100% of the charges incurred. Deductible does not apply. 90% of the charges incurred. Deductible must first be satisfied.
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>G. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special dietary treatment for Phenylketonuria (PKU)</td>
</tr>
<tr>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>Out-of-Network Benefits</td>
</tr>
<tr>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral amino acid based elemental formula if it meets HealthPartners medical coverage criteria</td>
</tr>
<tr>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>Out-of-Network Benefits</td>
</tr>
<tr>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

Wigs for hair loss resulting from alopecia areata are subject to $350 maximum payment per plan year. No more than a three-month supply of diabetic supplies will be covered and dispensed at a time. Diabetic supplies purchased at a network pharmacy are not subject to the deductible.

<table>
<thead>
<tr>
<th>H. EMERGENCY AND URGENT CARE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convenience clinics</td>
</tr>
<tr>
<td>$15 copayment and 100% thereafter for the office visit charge. Deductible does not apply.</td>
</tr>
<tr>
<td>90% of the charges incurred for all other eligible services. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>Out-of-Network Benefits</td>
</tr>
<tr>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>H. EMERGENCY AND URGENT CARE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care provided at clinics</td>
</tr>
<tr>
<td>$25 copayment and 100% thereafter for the office visit charge. Deductible does not apply.</td>
</tr>
<tr>
<td>90% of the charges incurred for all other eligible services. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>Out-of-Network Benefits</td>
</tr>
<tr>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>H. EMERGENCY AND URGENT CARE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care in a hospital emergency room, including professional services of a physician</td>
</tr>
<tr>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>Out-of-Network Benefits</td>
</tr>
<tr>
<td>See Network Benefit.</td>
</tr>
</tbody>
</table>
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient emergency care in a hospital</td>
<td>See Network Inpatient Hospital Services Benefit.</td>
<td>See Network Benefit.</td>
</tr>
<tr>
<td></td>
<td>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</td>
<td>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</td>
</tr>
<tr>
<td></td>
<td>Out-of-network professional fees will be paid at the Network Inpatient Hospital Services Benefit level if the Covered Person is admitted inpatient to a network hospital through the emergency room.</td>
<td></td>
</tr>
</tbody>
</table>

I. HEALTH EDUCATION

Health education for preventive services is covered at the benefit level shown in the Preventive Services section.

J. HOME HEALTH SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapy, occupational therapy, speech therapy, respiratory therapy, home health aide services and palliative care</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>TPN/IV therapy, skilled nursing services, prenatal and postnatal services, child health services and phototherapy</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>Maximum visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 8 visits per plan year, for all other services that meet the home health services requirements described in this SB, there is a maximum of 120 visits per plan year.</td>
<td>If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 8 visits per plan year, for all other services that meet the home health services requirements described in this SB, there is a maximum of 60 visits per plan year.</td>
</tr>
<tr>
<td></td>
<td>Each Home Health Services visit provided under the Network Benefits and Out-of-Network Benefits counts toward the maximums shown above.</td>
<td></td>
</tr>
</tbody>
</table>

K. HOME HOSPICE SERVICES

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>Respite care is limited to 5 days per episode, and respite care and continuous care combined are limited to 30 days.</td>
<td></td>
</tr>
</tbody>
</table>
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>L. HOSPITAL AND SKILLED NURSING FACILITY SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Medical or Surgical Hospital Services</strong></td>
<td></td>
</tr>
<tr>
<td>a. Inpatient Hospital Services</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td></td>
<td>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</td>
</tr>
<tr>
<td></td>
<td>Each Covered Person's admission or confinement, including that of a newborn child, is separate and distinct from the admission or confinement of any other Covered Person.</td>
</tr>
<tr>
<td>b. Outpatient Hospital, Ambulatory Care or Surgical Facility Services (to see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see the benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy)</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td></td>
<td>Limited to 120 day maximum per period of confinement, subject to the combined day limit.</td>
</tr>
<tr>
<td></td>
<td>Each day of services provided under the Network Benefits and Out-of-Network Benefits, combined, counts toward the maximums shown above.</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care</strong></td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td></td>
<td>Limited to 120 day maximum per period of confinement, subject to the combined day limit.</td>
</tr>
</tbody>
</table>
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>M. INFERTILITY SERVICES</td>
<td>$25 copayment and 100% thereafter for the office visit charge. Deductible does not apply. 90% of the charges incurred for all other eligible services. Deductible must first be satisfied.</td>
<td>Infertility services for Network Benefits and Out-of-Network Benefits are limited to a combined $10,000 lifetime maximum benefit. Drugs for the treatment of infertility are subject to this maximum.</td>
<td></td>
</tr>
</tbody>
</table>

Injections for the treatment of infertility received in a physician’s office |

90% of the charges incurred. Deductible must first be satisfied. |

N. LABORATORY SERVICES |

The Plan covers services provided in a clinic or outpatient hospital facility. (To see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)

Associated with covered preventive services |

Laboratory for preventive services is covered at the benefit level shown in the Preventive Services section. |

For illness or injury |

100% of the charges incurred. Deductible does not apply. 90% of the charges incurred. Deductible must first be satisfied. |

O. MASTECTOMY RECONSTRUCTION BENEFIT |

Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services. |

Coverage level is same as corresponding Out-of-Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services. |

P. OFFICE VISITS FOR ILLNESS OR INJURY |

Office Visits |

$25 copayment and 100% thereafter for the office visit charge. Deductible does not apply. 90% of the charges incurred for all other eligible services. Deductible must first be satisfied. |

90% of the charges incurred. Deductible must first be satisfied.
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>Injections administered in a physician's office</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy injections</td>
<td>100% of the charges incurred. Deductible does not apply.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>All other injections</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

**Injectable and implantable birth control drugs/devices** (this provision applies whether the birth control drug/device is used for birth control or for a medically necessary purpose other than birth control)

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

**Convenience clinics**

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15 copayment and 100% thereafter for the office visit charge. Deductible does not apply.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>90% of the charges incurred for all other eligible services. Deductible must first be satisfied.</td>
<td></td>
</tr>
</tbody>
</table>

**Q. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY**

The Plan covers services provided in a clinic. The Plan also covers physical therapy provided in an outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25 copayment and 100% thereafter for the office visit charge/evaluations. Deductible does not apply.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>90% of the charges incurred for therapies. Deductible must first be satisfied.</td>
<td><strong>Physical, Occupational and Speech Therapy combined are limited to a plan year maximum of $500 per person.</strong></td>
</tr>
</tbody>
</table>
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th></th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R. PRESCRIPTION DRUG SERVICES</strong></td>
<td>Drugs and medications must be obtained at a network pharmacy</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Drugs</strong></td>
<td>$10 copayment and 100% thereafter per prescription for generic preferred drugs.</td>
<td>90% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td></td>
<td>$25 copayment and 100% thereafter per prescription for brand name preferred drugs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$40 copayment and 100% thereafter per prescription for non-preferred drugs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Drugs for the treatment of sexual dysfunction are limited to six doses per month.</em></td>
<td><em>Drugs for the treatment of sexual dysfunction are limited to six doses per month.</em></td>
</tr>
<tr>
<td>Specialty drugs which are self-administered</td>
<td>See Specialty Drugs Benefit under Network Benefits below.</td>
<td>See Specialty Drugs Benefit under Out-of-Network Benefits below.</td>
</tr>
<tr>
<td></td>
<td><em>Specialty drugs are limited to drugs on the specialty drug list, and must be obtained from a designated vendor.</em></td>
<td></td>
</tr>
<tr>
<td>Tobacco cessation products, as determined by HealthPartners.</td>
<td>Must be prescribed by a licensed provider. You are limited to a 180-day supply per plan year. No more than a 31-day supply will be covered and dispensed at a time.</td>
<td>See Network Outpatient Drugs Benefit.</td>
</tr>
</tbody>
</table>
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>Mail Order Drugs</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
</table>

You may also get outpatient prescription drugs which can be self administered through the HealthPartners mail order service. Drugs ordered through this service are covered at the benefit percent shown in Outpatient Drugs above, subject to two copayments for each 90-day supply or portion thereof.

Drugs for the treatment of sexual dysfunction are limited to 18 doses per 90-day supply.

For your convenience, you may also order oral contraceptives, insulin and tobacco cessation products through the mail order service without a discounted benefit.

Specialty drugs are limited to drugs on the specialty drug list and are not available through the mail order service.

For information on how to obtain drugs through the HealthPartners mail order service, refer to your enrollment material.

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

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Supplies purchased at a pharmacy</td>
<td>See Network Outpatient Drugs Benefit.</td>
<td>See Out-of-Network Outpatient Drugs Benefit.</td>
</tr>
<tr>
<td>Drugs for treatment of infertility</td>
<td>See Network Outpatient Drugs Benefit.</td>
<td>See Out-of-Network Outpatient Drugs Benefit.</td>
</tr>
<tr>
<td></td>
<td><em>Drugs for the treatment of infertility services are subject to the combined $10,000 lifetime maximum benefit for infertility services.</em></td>
<td></td>
</tr>
<tr>
<td>Specialty drugs which are self-administered</td>
<td>See Network Outpatient Drugs Benefit.</td>
<td>See Out-of-Network Outpatient Drugs Benefit.</td>
</tr>
<tr>
<td>Drugs for the treatment of growth deficiency</td>
<td>See Network Outpatient Drugs Benefit.</td>
<td>See Out-of-Network Outpatient Drugs Benefit.</td>
</tr>
<tr>
<td></td>
<td><em>Specialty drugs are limited to drugs on the specialty drug list, and must be obtained from a designated vendor.</em></td>
<td></td>
</tr>
<tr>
<td>Contraceptive barrier device</td>
<td>See Network Outpatient Drugs Benefit.</td>
<td>See Out-of-Network Outpatient Drugs Benefit.</td>
</tr>
</tbody>
</table>

Unless otherwise specified above in the Prescription Drug Services section, you may receive up to a 31-day supply per prescription. All drugs are subject to HealthPartners utilization review process and quantity limits. In addition, certain drugs may be subject to any quantity limits applied as part of the trial program for new prescriptions. A 90-day supply will be covered and dispensed at a time only at pharmacies that participate in the HealthPartners extended day supply program. No more than a 31-day supply of specialty drugs will be covered and dispensed at a time. If a copayment is required, you must pay one copayment for each 31-day supply or portion thereof, except as follows:

For oral contraceptives, one copayment will apply per three cycle supply.

For topical contraceptives, one copayment will apply per three cycle supply.

For mail order drugs, see benefit above.

S. PREVENTIVE SERVICES

1. Routine health exams and periodic health assessments
   - 100% of the charges incurred. Deductible does not apply.
   - 100% of the charges incurred. Deductible must first be satisfied.
   - $500 annual maximum*

2. Child health supervision services
   - 100% of the charges incurred. Deductible does not apply.
   - 100% of the charges incurred. Deductible must first be satisfied.
   - $500 annual maximum*

3. Routine prenatal services
   - 100% of the charges incurred. Deductible does not apply.
   - 100% of the charges incurred. Deductible must first be satisfied.
**COVERED SERVICES.** See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Routine postnatal services</strong></td>
<td>100% of the charges incurred. Deductible does not apply.</td>
</tr>
<tr>
<td><strong>5. Routine screening procedures for cancer</strong></td>
<td>100% of the charges incurred. Deductible does not apply.</td>
</tr>
<tr>
<td><strong>6. Routine eye and hearing exams</strong></td>
<td>100% of the charges incurred. Deductible does not apply.</td>
</tr>
<tr>
<td><strong>7. Professional voluntary family planning services</strong></td>
<td>100% of the charges incurred. Deductible does not apply.</td>
</tr>
<tr>
<td><strong>8. Adult immunizations</strong></td>
<td>100% of the charges incurred. Deductible does not apply.</td>
</tr>
</tbody>
</table>

*Limited to $500 per Plan Year combined under Out-of-Network Benefits.

**T. SPECIFIED OUT-OF-NETWORK SERVICES**

Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury.

See Network Benefits for the services covered.

**U. TRANSPLANT SERVICES**

See Network Inpatient Hospital Services Benefit.

See Out-of-Network Inpatient Hospital Services Benefit.

*Limited to 365 day maximum per period of confinement, subject to the combined day limit.*
CUSTOMER SERVICE

Enrollment and Eligibility Questions
Office of Student Health Benefits
410 Church Street SE, Room N323
Minneapolis, MN 55455
Phone: (612) 625-6936 or 1-800-232-9017
Fax: (612) 626-5183 or 1-800-624-9881
Email: umgahbo@umn.edu
http://www.shb.umn.edu

Coverage, Network, and Claims Questions
HealthPartners Member Services
Phone: (952) 883-7500 or 1-866-270-5434
Medical Residents: http://www.healthpartners.com/uofmgme
Pharmacy, Dental, and Veterinary Residents:
http://www.healthpartners.com/uofmres

Emergency Travel Assistance Questions
MEDEX
Phone: 1-800-527-0218
Email: info@medexassist.com
http://www.medexassist.com
<table>
<thead>
<tr>
<th><strong>SPECIFIC INFORMATION ABOUT THE PLAN</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of the Plan:</strong> The Plan shall be known as the University of Minnesota Residents and Fellows Health Benefit Plan which provides medical benefits.</td>
</tr>
<tr>
<td><strong>Address of the Plan:</strong> 410 Church Street SE, Room N323 Minneapolis, MN 55455 (612) 624-0627</td>
</tr>
<tr>
<td><strong>Group Number:</strong> 25000</td>
</tr>
<tr>
<td><strong>Plan Year:</strong> The initial plan year will have a 14 month term, commencing on May 1, 2010, and expiring on June 30, 2011. After the initial 14 month term, the Plan will automatically renew July 1.</td>
</tr>
<tr>
<td><strong>Plan Sponsor:</strong> University of Minnesota</td>
</tr>
<tr>
<td><strong>Agent for Service of Legal Process:</strong> General Counsel for University of Minnesota</td>
</tr>
<tr>
<td><strong>Named Fiduciary:</strong> University of Minnesota</td>
</tr>
<tr>
<td><strong>Funding:</strong> Claims under the Plan are paid from the general assets of the Plan Sponsor.</td>
</tr>
<tr>
<td><strong>Plan Manager:</strong> HealthPartners Administrators, Inc. 8170 33rd Avenue South P.O. Box 1309 Minneapolis, MN 55440-1309 (952) 883-6000</td>
</tr>
<tr>
<td><strong>Network Providers:</strong> HealthPartners Open Access Network</td>
</tr>
<tr>
<td><strong>Contributions:</strong> Please refer to the most recent enrollment material for information regarding contributions to your Plan which is hereby incorporated by this reference.</td>
</tr>
</tbody>
</table>
HEALTHPARTNERS MISSION

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

ABOUT HEALTHPARTNERS and the PLAN SPONSOR

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

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

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

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

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

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

This 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 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.

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

HealthPartners Trademarks. HealthPartners names and logos and all related products and service names, design marks and slogans are the trademarks of HealthPartners or its related companies.
I. INTRODUCTION TO THE SUMMARY OF BENEFITS

A. SUMMARY OF BENEFITS ("SB")

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

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

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

B. MEDICAL ADMINISTRATIVE SERVICES AGREEMENT ("ASA")

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

C. CONFLICT WITH EXISTING LAW

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

D. IDENTIFICATION CARD

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

E. HOW TO USE THE NETWORK

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

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

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

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

To obtain Network Benefits for covered services, you must select and receive services from network providers. There are limited exceptions as described in this SB.

Network. This is the network of participating network providers.

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

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

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

You may also request continuity of care benefits for culturally appropriate services or when we do not have a provider who can communicate with you directly or through an interpreter. Terminally ill patients are also eligible for continuity of care benefits. Occasionally, HealthPartners may, in its sole discretion, apply a previous carrier’s approach to coverage for a limited period of time to accommodate a member’s specific needs for continuity of care when a plan is moving from another carrier to HealthPartners coverage.

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

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

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

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

Contracted convenience care clinics are designated on www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Pharmacy, Dental, and Veterinary Residents). You must use a designated convenience care clinic to obtain the convenience care benefit.

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

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

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

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

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

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

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

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

**F. CARECHECK®**

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

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

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

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

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

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

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

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

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

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

**How to contact CareCheck®:** You may call (952) 883-6400 in the Minneapolis/St. Paul metro area, or 1-800-316-9807 outside the metro area, from 8:00 a.m. to 5:00 p.m. (Central Time) weekdays. You can leave a recorded message at other times. You may also write CareCheck® at Quality Utilization Management Department, 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

G. **ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, LATE ENROLLMENT, SPECIAL ENROLLMENT PERIOD, SPECIAL RULES RELATING TO MEDICAID AND CHIP, CHANGES IN BENEFITS AND TERMINATION**

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

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

2. **ENROLLMENT.** All persons eligible for coverage must enroll to obtain coverage under the health care plan. Enrollment cannot be accomplished through the online registration process. To enroll you must fill out the enrollment forms in the benefits packet provided by your department. Return the forms, by mail or in person, to the Office of Student Health Benefits, the mailing address is 410 Church Street S. E. Room N323 Minneapolis, MN 55455. The sooner you enroll the sooner you will receive an identification card that shows your eligibility for health care. (If you need health care before receiving the card, your health care provider may contact the Office of Student Health Benefits to verify your enrollment and eligibility.) If you elect dependent coverage you will need to submit payment for the cost of the first two months of coverage with your enrollment forms to the Office of Student Health Benefits.

3. **EFFECTIVE DATE.** Coverage will be effective as determined by the Plan Sponsor.

4. **LATE ENROLLMENT.** If you are a late enrollee, you may enroll yourself and any eligible dependents at any time.
5. **SPECIAL ENROLLMENT PERIOD.** A Covered Person, who is eligible, but not enrolled for coverage under the Plan, may enroll for coverage under the terms of the Plan if all of the following conditions are met:

a. you or your dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to you or your dependent;

b. you stated in writing at the time of initial eligibility that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the Plan Sponsor required such a statement at such time and provided you with notice of such requirement and the consequences of such requirement at such time;

c. you or your dependent's coverage described in a. above was:
   (1) under a COBRA continuation provision and the coverage under such provision was exhausted; or
   (2) not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including: as a result of legal separation; divorce; death; termination of employment; cessation of dependent status; reduction in the number of hours of employment; a situation in which the individual incurs a claim that would meet or exceed a lifetime limit on all benefits; a situation in which coverage is no longer offered to a class of similarly situated individuals that includes the individual; a situation in which an individual loses coverage through a health maintenance organization or other arrangement because that individual no longer resides, lives or works in the health maintenance organization’s service area or a situation in which the individual’s benefit option is terminated) or employer contributions toward such coverage were terminated; and

d. you requested such enrollment not later than 31 days after the date of exhaustion of coverage described in c. (1) above, or one of the events listed in c. (2) above.

Dependent beneficiaries may enroll if: (a) a group health plan makes coverage available with respect to a dependent of yours; (b) you are covered under the Plan (or have met any waiting period applicable to becoming a participant under the Plan and is eligible to be enrolled under the Plan but for a failure to enroll during a previous enrollment period); and (c) a person becomes a dependent of yours through marriage, birth, or adoption or placement for adoption. The Plan shall provide for a dependent Special Enrollment Period during which the person (or, if not otherwise enrolled, the resident/fellow) may be enrolled under the Plan as a dependent of you and in the case of the birth or adoption of a child, your spouse may be enrolled as a dependent of you if such spouse is otherwise eligible for coverage. A dependent Special Enrollment Period shall be a period of not less than 31 days and shall begin on the later of:

a. the date dependent coverage is made available; or

b. the date of the marriage, birth, or adoption or placement for adoption described in (c) in the paragraph above.

If an individual seeks to enroll a dependent during the first 31 days of such a dependent Special Enrollment Period, the coverage of the dependent shall become effective:

a. in the case of marriage, the date of marriage;

b. in the case of a dependent's birth, as of the date of such birth; or

c. in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.
6. **SPECIAL RULES RELATING TO MEDICAID AND CHIP**

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

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

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

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

8. **TERMINATION.** A Covered Person's coverage under the Plan terminates when any of the following events occur:

a. The contribution for coverage under the Plan is not made by the due date.

b. When you cease to be eligible under the terms of this Plan, coverage for you and all Covered Dependents terminates on the last day of the month in which your eligibility ceases, unless group continuation is elected as described in section VII.A.

c. When a Covered Dependent no longer meets this Plan's definition of Eligible Dependent, coverage for that dependent terminates on the last day of the month in which the dependent's eligibility ceases, unless group continuation is elected as described in section VII.A.

d. When the maximum period under the group continuation coverage described in section VII.A. expires for a Covered Person.

e. When the Plan terminates.

f. In the event of misrepresentation or omission of a material fact by the Covered Person regarding eligibility, enrollment, other coverage, claims or other expenses, the Plan Sponsor has the right to rescind this Summary of Benefits or disenroll the Covered Person.

g. The date charges are incurred that result in payment up to the lifetime maximum.
H. PRIVACY OF PROTECTED HEALTH INFORMATION

University of Minnesota Residents and Fellows Health Plan

NOTICE OF PRIVACY PRACTICES Effective August 24, 2009

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

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

1. PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

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

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

While this notice is in effect, the Plan must follow the privacy practices described. This notice takes effect on the date shown at the top of this form, and will remain in effect until it is replaced. The Plan reserves the right to change its privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. The Plan reserves the right to make such changes effective for all protected health information that the Plan maintains, including information created or received before the changes were made.

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

2. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

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

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

b. Health Care Operations: The Plan may use and disclose protected health information about you for health care operations. These uses and disclosures are necessary to operate the Plan. For example, the Plan uses and discloses protected health information to conduct quality assessment and improvement activities, and for cost management and business management purposes.
c. **Treatment:** The Plan may use or disclose protected health information for treatment purposes, including helping providers to coordinate your care. Only the minimum amount of information necessary will be disclosed. For example, an emergency care provider may contact the Plan to find out what other providers you use, so that he or she can contact them to get medical records necessary to your care, if you are unable to provide that information.

d. **Disclosures to the Plan Sponsor:** The Plan may disclose your protected health information to the University of Minnesota, which sponsors the Plan, but only to permit the University to perform Plan administration functions. These disclosures may be made only to the administrative units of the University, primarily the Office of Student Health Benefits, involved in Plan administration, and will be strictly limited to disclosures necessary for Plan administration purposes.

e. **Disclosures to Other Plans:** Each plan sponsored by the University of Minnesota may disclose your protected health information to another health plan sponsored by the University of Minnesota to facilitate claims payment and certain health care operations of the other plan.

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

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

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

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

h. **Communication about Benefits, Products and Services:** The Plan may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives, or to tell you about health-related products or services (or payment or coverage for such products or services) that may be of interest to you. The Plan may use your protected health information to contact you with information about benefits under the Plan, including certain communications about health plan networks, health plan changes, and value-added health plan-related products or services. The Plan may communicate with you face-to-face regarding any benefits, products or services. The Plan may use or disclose protected health information to distribute small promotional gifts.
i. **Required by Law:** The Plan may use or disclose your protected health information when required to do so by law. For example, disclosures to the Secretary of Health & Human Services for the purpose of determining the Plan’s compliance with federal privacy law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

e. Restriction Requests: You have the right to request that the Plan place additional restrictions on its use or disclosure of your protected health information for treatment, payment, or health care operations. The Plan is not required to agree to these restrictions, but if it does, the Plan will abide by its agreement (except in an emergency). Any such agreement by the Plan must be in writing signed by a person authorized to make such an agreement on our behalf; without this written agreement, the Plan will not be bound by the requested restrictions. Please use the contact information at the end of this notice to get more information about how to make such a request.
f. **Confidential Communication:** You have the right to request that the Plan communicate with you about your protected health information by alternative means or to an alternative location. For example, you may ask that the Plan contact you only at work or by mail. You must make your request in writing and must specify how or where you wish to be contacted. Your request must state that the information could endanger you if it is not communicated in confidence as you request. The Plan will accommodate all reasonable requests. Please use the contact information at the end of this notice to get more information about how to make such a request.

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

4. **QUESTIONS**

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

Office of Student Health Benefits  
University of Minnesota  
410 Church Street SE, Room N323  
Minneapolis, MN 55455  
Telephone: (612) 624-0627 or 1-800-232-9017 (out of area)

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

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

I. **YOUR RIGHT TO A CERTIFICATE OF COVERAGE UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

HIPAA rules require Plan Sponsors to send Certificates of Coverage (also referred to as “HIPAA Certs” or “Certs”) to all individuals currently or previously covered under their medical plan. The Plan Sponsor may elect to send their own or have their third party administrator/Plan Manager (HPAI) send Certificates of Coverage.

Certificates of Coverage are documents that provide evidence of your prior or current medical coverage. Certificates of Coverage reflect the length of continuous medical coverage that you had under the Plan Sponsors’ Plan.

When your medical coverage is terminated, you will automatically be sent a Certificate of Coverage. You will also be sent a Certificate of Coverage anytime you request one. If you request a Certificate of Coverage while you have active medical coverage under the Plan, your Certificate of Coverage will indicate that your coverage is ‘continuing’. You may request a Certificate of Coverage by calling Member Services phone number or writing to the address printed on your identification card.

According to HIPAA rules, Plan Sponsors must produce original Certificates of Coverage for a minimum of 24 months after the date that your medical coverage under the Plan Sponsors’ Plan terminates.
II. DEFINITIONS OF TERMS USED

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

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

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

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

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

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

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

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

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

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

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

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

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

**Eligible Dependents.** (FOR THE PURPOSES OF THIS DEFINITION, YOU OR YOUR REFERS TO THE COVERED RESIDENT/FELLOW.) These are the persons shown below. Under the Plan, a person who is considered a Covered Resident/Fellow is not qualified as an eligible dependent. A person who is no longer an eligible dependent (as defined below) on your Plan may qualify for continuation of coverage within the group as provided in section VII. of this SB.

Please note, for Covered Dependents who do not meet the definition of either a “qualifying child” or a “qualifying relative” under Internal Revenue Code Section 152, payments made by the Plan Sponsor under this Plan for covered services may result in taxable income to you. Please consult with your Plan Sponsor or tax advisor regarding your individual situation.

1. **Spouse.** This is your current legal spouse. If more than one spouse is covered as a Resident/Fellow under the Plan, only one spouse shall be considered to have any eligible dependents.
2. **Child.** This is your (a) unmarried natural or legally adopted child (effective from the date of adoption or the date placed for adoption, whichever is earlier); (b) unmarried grandchild; (c) unmarried child for whom the you or your spouse is the legal guardian; (d) your unmarried step-child (that is, the child of your spouse); or (e) a child covered under a valid qualified medical child support order (as the term is defined by applicable law) which is enforceable against a Covered Person.* In each case the child must be either under 25 years of age or a disabled dependent, as described below. In order to qualify as a dependent under clause (b) or (d) above, the child must be dependent on you for a majority of his or her financial support.

3. **Disabled Dependent.** This is your dependent as referred to in 2. above, who is beyond the limiting age and is physically handicapped or mentally disabled, and dependent on you for the majority of his/her financial support. The disability must have come into existence prior to attainment of age 25. Disability does not include pregnancy. "Disabled" means incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap. You must give the Plan Sponsor a written request for coverage of a disabled dependent. The request must include written proof of disability and must be approved by the Plan Sponsor, in writing. The Plan Sponsor must receive the request within 31 days of the date an already enrolled dependent becomes eligible for coverage under this definition, or when adding a new disabled dependent eligible under this definition. The Plan Sponsor reserves the right to periodically review disability, provided that after the first two years, the Plan Sponsor will not review the disability more frequently than once every 12 months.

4. **Domestic Partner.** Refers to two persons of the same gender, age 18 or older, who are not related by blood closer than permitted by the state of Minnesota marriage laws. The persons declare that they are each other's sole domestic partner and are responsible for each other's welfare.

   This definition is intended to cover same-sex relationships — people who are partners and not roommates. Domestic partnership is defined as two individuals of the same gender who are in a committed relationship of an indefinite duration, who support each other, and whose relationship resembles a mutually exclusive partnership as that of marriage.

   Domestic Partner Registration: You must complete an affidavit registering your domestic partnership in order to be eligible for benefits. Complete a Declaration of Domestic Partnership and send to Employee Benefits. Registration and application for benefits must take place within the first 60 days of your hire date or within 30 days of a family status change.

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

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

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

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

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

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*A description of the procedures governing qualified medical child support order determinations can be obtained by participants and beneficiaries, without charge, from the Plan Sponsor.*
**Health Care Provider.** This is any licensed non-physician (excluding naturopathic providers), lawfully performing a medical service in accordance with applicable governmental licensing privileges and limitations, who renders direct patient care to Covered Persons as covered under the Plan.

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

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

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

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

1. Whether there is final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the U.S. Food and Drug Administration (FDA); if the drug or device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and
2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in the American Hospital Formulary Service as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility studying the same drug, device, medical treatment or procedure.

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

1. Appropriate for the symptoms, diagnosis or treatment of your medical condition;
2. Consistent with evidence-based standards of medical practice where applicable;
3. Not primarily for your convenience or that of your family, your physician, or any other person; and
4. The most appropriate and cost-effective level of medical services or supplies that can be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided in a lower level of care setting. The fact that a physician, participating provider, or any other provider, has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed you of its availability, does not in itself make it medically necessary.

**Medicare.** This is the federal government's health insurance program under Social Security Act Title XVIII, as amended. Medicare provides medical benefits to people who are 65 or older, or who are permanently disabled. The program has two parts: Part A and Part B. Part A generally covers the costs of hospitals and extended care facilities. Part B generally covers the costs of professional medical services. Both parts are subject to Medicare deductibles.
Mental Health Professional. This is a psychiatrist, psychologist, or mental health therapist licensed for independent practice, lawfully performing a mental or chemical health service in accordance with governmental licensing privileges and limitations, who renders mental or chemical health services to Covered Persons as covered under the Plan. For inpatient services, these mental health professionals must be working under the order of a physician.

Non-Preferred Drug. This is a prescription drug which is not on the preferred drug list, is medically necessary and is not investigatory or otherwise excluded under this Plan.

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

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

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

Plan Year. The first plan year is the period beginning at 12:01 A.M. Central Time, on May 1, 2010, and ending 12:00 A.M. Central Time June 30, 2011. All subsequent plan years will begin at 12:01 A.M. Central Time, on July 1, and ending 12:00 A.M. Central Time June 30.

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

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

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

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

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

Skilled Nursing Facility. This is a licensed skilled nursing facility, lawfully performing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility by the Plan, to render inpatient post-acute hospital and rehabilitative care and services to Covered Persons, whose condition requires skilled nursing facility care. It does not include facilities which primarily provide treatment of mental or chemical health, or tuberculosis.
Specialty Drug List. This is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies, which are typically bio-pharmaceuticals. The purpose of a specialty drug list is to facilitate enhanced monitoring of complex therapies used to treat specific conditions. The specialty drug list is available on-line at www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Pharmacy, Dental, and Veterinary Residents) or by calling Member Services.

III. DESCRIPTION OF COVERED SERVICES

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

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

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

A. ACUPUNCTURE

The Plan covers acupuncture services when medically necessary.

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

B. AMBULANCE AND MEDICAL TRANSPORTATION

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

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

C. BEHAVIORAL HEALTH SERVICES

1. Mental Health Services

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

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

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

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

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

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

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

2. **Chemical Health Services**

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

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

Outpatient services covered by the Plan for a diagnosed chemical dependency condition include the following:
1. Individual, group, family, and multi-family therapy provided in an office setting;
2. Opiate replacement therapy including methadone and buprenorphine treatment; and
3. Day treatment and intensive outpatient services in a licensed program.

b. **Inpatient Services:** The Plan covers inpatient services in a hospital or a licensed residential primary treatment center.

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

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

**D. CHIROPRACTIC SERVICES**

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

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

**E. DENTAL SERVICES**

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

2. **Medical Referral Dental Services.**
   a. **Medically Necessary Outpatient Dental Services.** The Plan covers certain medically necessary outpatient dental services. Coverage is limited to dental services required for treatment of an underlying medical condition, e.g., removal of teeth to complete radiation treatment for cancer of the jaw, cysts and lesions.
   b. **Medically Necessary Hospitalization and Anesthesia for Dental Care.** The Plan covers certain medically necessary hospitalization for dental care. This is limited to charges incurred by a Covered Person who: (1) is a child under age 5; (2) is severely disabled; (3) has a medical condition, and requires hospitalization or general anesthesia for dental care treatment; or (4) is a child between age 5 and 12 and care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful, or when extensive amounts of restorative care, exceeding 4 appointments, are required. The requirement of a hospital setting must be due to a Covered Person's underlying medical condition. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist professional fees are not covered. The following are examples, though not all-inclusive, of medical conditions which may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Hospitalization required due to the behavior of the Covered Person or due to the extent of the dental procedure is not covered.
   c. **Medical Complications of Dental Care.** The Plan covers certain medical complications of dental care. Treatment must be medically necessary care and related to significant medical complications of non-covered dental care, including complications of the head, neck, or substructures.

3. **Orthognathic Surgery Benefit.** The Plan covers orthognathic surgery for the treatment of severe dysmophia where a functional occlusion can not be achieved through non-surgical treatment alone and where a demonstrable functional impairment exists. Functional impairments include but are not limited to significant impairment in chewing, breathing or swallowing. Associated dental or orthodontic services (pre- or post-operatively including surgical rapid palatal expansion) are not covered as a part of this benefit.
4. **Treatment of Cleft Lip and Cleft Palate.** The Plan covers certain treatment of cleft lip and cleft palate of a dependent child, to the limiting age in the definition of an “Eligible Dependent”, including orthodontic treatment and oral surgery directly related to the cleft. Benefits for individuals age 19 up to the limiting age for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. Dental services which are not necessary for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under the Plan is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same copayment, conditions and limitations as durable medical equipment.

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

F. **DIAGNOSTIC IMAGING SERVICES**

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

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

G. **DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES**

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

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

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

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

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

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

3. Items which are not eligible for coverage include, but are not limited to:
   a. Replacement or repair of any covered items, if the items are: (1) damaged or destroyed by misuse; abuse or carelessness; (2) lost; or (3) stolen.
   b. Duplicate or similar items.
   c. Labor and related charges for repair of any covered items which are more than the cost of replacement by a designated vendor.
d. Sales tax, mailing, delivery charges, service call charges.

e. Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation.

f. Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, hearing aids (implantable and external, including osseointegrated or bone anchored), fitting of hearing aids, speech processors, receivers, communication boards, or computer or electronic assisted communication, except as specifically described in this SB. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by calling Member Services, or on-line at www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Pharmacy, Dental, and Veterinary Residents).

g. Household equipment which primarily has customary uses other than medical, such as, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds.

h. Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools, whirlpools and saunas.

i. Modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment.

j. Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carriers.

k. Rental equipment while the Covered Person's owned equipment is being repaired, beyond one month rental of medically necessary equipment.

l. Other equipment and supplies, including but not limited to assistive devices, that the Plan determines are not eligible for coverage.

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

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

H. EMERGENCY AND URGENT CARE SERVICES

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

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

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

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

The Plan covers services for emergency care and urgently needed care if the services are otherwise eligible for coverage in this SB.
**Emergency Travel Assistance Program.** Plan members and their dependents traveling 100 or more miles away from home and outside of their home country, have emergency medical, travel and personal security assistance 24 hours a day, anywhere in the world, through MEDEX, a leading provider of international travel assistance services. From finding an English-speaking doctor to replacing a prescription, MEDEX has the resources and experience to offer rapid coordination and monitoring of medical care while you are abroad. This benefit is not offered by HealthPartners. It is provided by the University of Minnesota through MEDEX. For more information, contact MEDEX by phone at 1-800-527-0218 or on-line at http://www.medexassist.com.

I. **HEALTH EDUCATION**

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

J. **HOME HEALTH SERVICES**

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

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

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

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

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

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

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

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

Applicable Definitions:

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

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

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

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

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

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

   b. Eligible Services: Hospice services include the following services provided by Medicare-certified providers, if provided in accordance with an approved hospice treatment plan.

      (1) Home Health Services:

         (a) Part-time care provided in the Covered Person's home by an interdisciplinary hospice team (which may include a physician, nurse, social worker, and spiritual counselor) and medically necessary home health services are covered.

         (b) One or more periods of continuous care in the Covered Person's home or in a setting which provides day care for pain or symptom management, when medically necessary, will be covered.

      (2) Inpatient Services: The Plan covers medically necessary inpatient services.

      (3) Other Services:

         (a) Respite care is covered for care in the Covered Person's home or in an appropriate facility, to give the patient's primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain a terminally ill patient at home.

         (b) Medically necessary medications for pain and symptom management.

         (c) Medically necessary semi-electric hospital beds and other durable medical equipment are covered.

         (d) Medically necessary emergency and non-emergency care are covered.

2. What Is Not Covered. The Plan does not cover the following services:

   a. financial or legal counseling services; or

   b. housekeeping or meal services in the patient's home; or

   c. custodial care related to hospice services, whether provided in the home or in a nursing home; or

   d. any service not specifically described as a covered service under this home hospice services section; or

   e. any services provided by a member of the patient's family or resident in the Covered Person's home.
L. HOSPITAL AND SKILLED NURSING FACILITY SERVICES

1. Medical or Surgical Hospital Services

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

   Inpatient hospital services include: room and board; the use of operating or maternity delivery rooms; intensive care facilities; newborn nursery facilities; general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, prescription drugs or other medications administered during treatment, blood and blood products (unless replaced) and blood derivatives, and other diagnostic or treatment related hospital services; physician and other professional medical and surgical services provided while in the hospital.

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

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

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

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

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

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

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

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

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

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

M. INFERTILITY SERVICES

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

N. LABORATORY SERVICES

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

O. MASTECTOMY RECONSTRUCTION BENEFIT

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

P. OFFICE VISITS FOR ILLNESS OR INJURY

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

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

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

Q. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

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

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

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

R. PRESCRIPTION DRUG SERVICES

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

The Plan covers the following preventive services:

1. Routine health exams and periodic health assessments. A physician or health care provider will counsel Covered Persons as to how often health assessments are needed based on the age, sex and health status of the Covered Person.
2. Child health supervision services, including pediatric preventive services, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months, and appropriate immunizations to age 18.
3. Routine prenatal care and exams to include visit-specific screening tests, education and counseling.
4. Routine postnatal care and exams to include health exams, assessments, education and counseling relating to the period immediately after childbirth.
5. Routine screening procedures for cancer.
6. Routine eye and hearing exams.
7. Professional voluntary family planning services.
8. Adult immunizations.

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

T. SPECIFIED OUT-OF-NETWORK SERVICES

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

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

U. TRANSPLANT SERVICES

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

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

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

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

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

**Designated Transplant Center.** This is any health care provider, group or association of health care providers designated by the Plan to provide services, supplies or drugs for specified transplants for Covered Persons.
Transplant Services. This is transplantation (including retransplants) of the human organs or tissue listed below, including all related post-surgical treatment and drugs and multiple transplants for a related cause. Transplant services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of FDA approved Ventricular Assist Devices (VAD), functioning as a temporary bridge to heart transplantation.

What is covered. The Plan covers eligible transplant services (as defined above) while you are a Covered Person. Transplants that will be considered for coverage are limited to the following:
1. Kidney transplants for end-stage disease.
2. Cornea transplants for end-stage disease.
3. Heart transplants for end-stage disease.
4. Lung transplants or heart/lung transplants for: (a) primary pulmonary hypertension; (b) Eisenmenger's syndrome; (c) end-stage pulmonary fibrosis; (d) alpha 1 antitrypsin disease; (e) cystic fibrosis; and (f) emphysema.
5. Liver transplants for: (a) biliary atresia in children; (b) primary biliary cirrhosis; (c) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (d) primary sclerosing cholangitis; (e) alcoholic cirrhosis; and (f) hepatocellular carcinoma.
6. Allogeneic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (a) acute myelogenous leukemia; (b) acute lymphocytic leukemia; (c) chronic myelogenous leukemia; (d) severe combined immunodeficiency disease; (e) Wiskott-Aldrich syndrome; (f) aplastic anemia; (g) sickle cell anemia; (h) non-relapsed or relapsed non-Hodgkin’s lymphoma; (i) multiple myeloma; and (j) testicular cancer.
7. Autologous bone marrow transplants or peripheral stem cell support associated with high-dose chemotherapy for: (a) acute leukemias; (b) non-Hodgkin's lymphoma; (c) Hodgkin's disease; (d) Burkitt's lymphoma; (e) neuroblastoma; (f) multiple myeloma; (g) chronic myelogenous leukemia; and (h) non-relapsed non-Hodgkin’s lymphoma.

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

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

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

The list of eligible transplant services and coverage determinations are based on established medical policies which are subject to periodic review and modification by HealthPartners medical director.
IV. EXCLUSIONS

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

1. Treatment, procedures, services or drugs which are not medically necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the Covered Person, including cognitive retraining and skills training.
2. Treatment, procedures, or services or drugs which are provided when you are not covered under this Plan.
3. For Network Benefits, treatment, procedures or services which are not provided by a network physician or other authorized network provider.
4. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical services. The Plan considers vagus nerve stimulator treatment for the treatment of depression and Quantitative Electroencephalogram treatment for the treatment of behavioral health conditions to be investigative and does not cover these services. The Plan considers the following transplants to be investigative and does not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this SB. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
5. Rest and respite services and custodial care. This includes all services, medical equipment and drugs provided for such care.
6. Room and board and care provided in halfway houses, residential treatment services, extended care facilities, or comparable facilities, foster care, adult foster care and family child care provided or arranged by the local state or county.
7. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.
8. Services from non-medically licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.
9. Cosmetic surgery, cosmetic services and treatments primarily for the improvement of the Covered Person's appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for port wine stain removal and reconstructive surgery.
10. All services for weight loss programs and drugs.
11. Dental treatment, procedures or services not listed in this SB.
12. Vocational rehabilitation and recreational or educational therapy.
13. Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations, and adoption studies.
14. Reversal of sterilization; assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI) and/or in-vitro fertilization (IVF), and all charges associated with such procedures; treatment of infertility after reversal of sterilization; artificial insemination when not medically necessary for the treatment of a Covered Person's medically diagnosed infertility; surrogate pregnancy and related obstetric/maternity benefits; sperm, ova or embryo acquisition, retrieval or storage.
15. Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, measurement and adjustment, and hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this SB. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by calling Member Services, or on www.healthpartners.com/uofmgme (Medical Residents) or www.healthpartners.com/uofmres (Pharmacy, Dental, and Veterinary Residents).
16. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as specified in this SB. This exclusion does not apply to oral amino acid based elemental formula if it meets HealthPartners medical coverage criteria.
17. Charges for sales tax.
18. Services provided by a family member of the Covered Person, or a resident in the Covered Person's home.
20. Private duty nursing services.
21. Services that are rendered to a Covered Person, who also has other primary insurance coverage for those services and who does not provide the Plan the necessary information to pursue coordination of benefits, as required under the Plan.
22. The portion of a billed charge for an otherwise covered service by a provider, which is in excess of the usual and customary charges, or which is either a duplicate charge for a service or charges for a duplicate service.
23. Charges for services (a) for which a charge would not have been made in the absence of insurance or medical plan coverage, or (b) which the Covered Person is not legally obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the Covered Person.
24. Travel and lodging incidental to travel, regardless if it is recommended by a physician and any travel billed by a provider.
25. Health club memberships.
26. Massage therapy for the purpose of a Covered Person's comfort or convenience.
27. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
29. For Network Benefits, charges incurred for transplants, Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) received at facilities which are not designated facilities, or charges incurred for weight loss services provided by a physician who is not a designated physician.
30. Accident related dental services if treatment is (1) provided to teeth which are not sound and natural, (2) to teeth which have been restored, (3) initiated beyond twelve months from the date of the injury, (4) received beyond the initial treatment or restoration, or (5) received beyond twenty-four months from the date of injury.
31. Nonprescription (over-the-counter) drugs or medications, unless listed on the preferred drug list and prescribed by a physician or legally authorized health care provider under applicable state law, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs.
32. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including ABA, IEIBT, and Lovaas.
33. Charges for elective home births.
34. Professional services associated with substance abuse intervention. A “substance abuse intervention” is a gathering of family and/or friends to encourage a person covered under this SB to seek substance abuse treatment.
35. Court ordered treatment, except as described under “Mental Health Services” and “Office Visits for Illness and Injury” or as otherwise required by law.
36. Services provided through scheduled telephone visits and services provided through E-Visits.
37. Charges provided by naturopathic providers.
38. Oral surgery including oral surgery to remove wisdom teeth.

V. DISPUTES AND COMPLAINTS

A. DETERMINATION OF COVERAGE

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

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

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

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

Complaints must be made to:
HealthPartners
Member Services Department
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN  55440-1309
Telephone:  (952) 883-7500        Outside the metro area:  1-866-270-5434
TDD Telephone Number:  (952) 883-5127    Outside the metro area: 1-888-850-4762

VI. CONDITIONS

A. RIGHTS OF REIMBURSEMENT AND SUBROGATION

If services are provided or paid for under the Plan to treat an injury or illness: (1) caused by the act or omission of another party; (2) covered by no fault or employers liability laws; (3) available or required to be furnished by or through national or state governments or their agencies; or (4) sustained on the property of a third party, the Plan Sponsor or its designee has the right to recover the reasonable value of services and payments made. This right shall be by reimbursement and subrogation. The right of reimbursement means you must repay the Plan Sponsor or its designee at the time you make any recovery. Recovery means all amounts received by you from any persons, organizations or insurers by way of settlement, judgment, award or otherwise on account of such injury or illness. The right of subrogation means that the Plan Sponsor or its designee may make claim in your name or the Plan Sponsor's name against any persons, organizations or insurers on account of such injury or illness. Attorneys' fees and expenses incurred by a Covered Person in connection with the recovery of monies from third parties may not be deducted from subrogation/reimbursement amounts, unless agreed to by the Plan Sponsor in its discretion.

In addition, the Plan will have a lien on any amounts payable by a third party or under an insurance policy or program, to the extent covered expenses are paid by the Plan Sponsor's Medical Benefit Plan.

The rights of reimbursement and subrogation apply whether or not the Covered Person has been fully compensated for losses or damages by any recovery of payments, and the Plan Sponsor or its designee will be entitled to immediately collect the present value of subrogation rights from said payments.

If, after recovery of any payments, you receive services or incur expenses on account of such injury or illness, you may be required to pay for such services or expenses. The total of all reimbursement and payments will not exceed your recovery.

This right of reimbursement and subrogation applies to any type of recovery from any third party, including but not limited to recoveries from tortfeasors, underinsured motorist coverage, uninsured motorist coverage, medical payments coverage, other substitute coverage or any other right of recovery, whether based on tort, contract, equity or any other theory of recovery. The right of reimbursement is binding upon you, your legal representative, your heirs, next of kin and any trustee or legal representative of your heirs or next of kin in the event of your death. Any amounts you receive from such a recovery must be held in trust for the Plan's benefit to the extent of subrogation claims.

You agree to cooperate fully in every effort by the Plan Sponsor or its designee to enforce the rights of reimbursement and subrogation. You also agree that you will not do anything to interfere with those rights. You agree to promptly inform the Plan Sponsor in writing of any situation or circumstance which may allow the Plan Sponsor to invoke its rights under this section.
B. COORDINATION OF BENEFITS

You agree, as a Covered Person, to permit the Plan Manager to coordinate payments under any other medical benefit plans as specified below, which cover you or your dependents. You also agree to provide any information or submit any claims to other medical benefit plans necessary for this purpose. If you fail to provide this information, your claim may be delayed or denied. You agree to authorize the Plan Manager's billing to other medical plans, for purposes of coordination of benefits.

Unless applicable law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under the Plan must provide any facts needed to pay the claim.

1. Applicability.
   a. This Coordination of Benefits (COB) provision applies to the Plan when a Covered Person has medical care coverage under more than one plan. "Plan" and "The Plan" are defined below.
   b. If this Coordination of Benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of The Plan are determined before or after those of another plan. The benefits of The Plan:
      (1) shall not be reduced when, under the order of benefit determination rules, benefits under The Plan are determined before another plan; but
      (2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in paragraph 4. below.

2. Definitions.
   a. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
      (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
      (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
   b. "The Plan" is the part of the Plan that provides benefits for medical care expenses.
   c. "Primary Plan/Secondary Plan" The order of benefit determination rules state whether The Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When The Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When The 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 there are more than two plans covering the person, The Plan may be a Primary Plan as to one or more of the plans and may be a Secondary Plan as to a different plan or plans.
   d. "Allowable Expense" is a necessary, reasonable and customary item of expense for medical care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the 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. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements.
e. **“Claim Determination Period”** is a plan year. However, it does not include any part of a year during which a person has no coverage under The Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. **Order of Benefit Determination Rules.**
   a. **General.** When there is a basis for a claim under The Plan and another plan, The Plan is a Secondary Plan which has its benefits determined after those of another plan, unless:
   1. the other plan has rules coordinating its benefits with those of The Plan; and
   2. both those rules and The Plan's rules, in subparagraph b. below, require that The Plan's benefits be determined before those of the other plan.

   b. **Rules.** The order of benefits are determined using the first of the following rules which applies:
   1. Nondependent/Dependent. The benefits of the plan which cover the person as a covered person or subscriber (that is, other than as a dependent) are determined before those of the plan which cover the person as a dependent.
   2. Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph b. (3) below, when The Plan and another plan cover the same child as a dependent of different persons, called "parents":
      a. the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
      b. if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
   3. Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
      a. first, the plan of the parent with custody of the child;
      b. then, the plan of the spouse of the parent with the custody of the child; and
      c. finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the medical care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
   4. Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for medical care expenses of the child, the plans covering the child follow the order of benefit determination rules outlined in subparagraph b. (2).
   5. Active/Inactive Enrollee. The benefits of a plan which covers a person as a covered employee who is neither laid off nor retired (or as that covered employee's dependent) are determined before those of a plan which cover that person as a laid off or retired covered employee (or as that covered 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, this rule is ignored.
   6. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered a covered person or subscriber longer are determined before those of the plan which covered that person for the shorter term.
4. **Effect on the Benefits of this Plan.**
   a. **When this Section Applies.** This paragraph 4. applies when, in accordance with paragraph 3. "Order of Benefit Determination Rules", The Plan is a Secondary Plan as to one or more other plans. In that event the benefits of The Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in b. immediately below.
   b. **Reduction in the Plan's Benefits.** The benefits of The Plan will be reduced when the sum of:
      (1) the benefits that would be payable for the Allowable Expense under The Plan in the absence of this COB provision; and
      (2) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of The Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of The Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of The Plan.

5. **Right to Receive and Release Needed Information.** Certain facts are needed to apply these COB rules. The Plan Manager has the right to decide which facts are needed. Consistent with applicable state and federal law, the Plan Manager may get needed facts from or give them to any other organization or person, without your further approval or consent. Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under The Plan must give any facts the Plan Manager needs to pay the claim.

6. **Facility of Payment.** A payment made under another plan may include an amount which should have been paid under The Plan. If it does, the Plan Sponsor may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under The Plan. The Plan Sponsor 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.

7. **Right of Recovery.** If the amount of the payments made by the Plan Sponsor is more than the amount that should have paid under this COB provision, the Plan Manager may recover the excess from one or more of:
   a. the persons it has paid or for whom it has paid;
   b. insurance companies; or
   c. other organizations.
The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

The benefits provided by the Plan do not apply to injury or disease covered by no-fault insurance, employers liability laws (including workers' compensation), and care available or required to be furnished by or through national or state governments or their agencies including care to which a covered person is legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities. Subject to the Plan's rights in A. "Rights of Reimbursement and Subrogation" above, medically necessary services will be provided upon request and only expenses incurred for medical treatment otherwise covered by the Plan will be paid if the no-fault insurer, employer, or national or state government or its agencies refuse to pay said expenses. You must cooperate with the Plan Manager's program to bill allowable no-fault and workers' compensation claims to the appropriate insurer(s).
C. **MEDICARE AND THE PLAN**

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

Medicare is the primary payer for Covered Persons with end stage renal disease, after the 30 month period following the earlier of (1) the month in which the Covered Person begins a regular course of renal dialysis, or (2) the first of the month in which the Covered Person became entitled to Medicare, if the Covered Person received a kidney transplant without first beginning dialysis. This is regardless of the size of the Employer. Medicare is primary payer for retirees who are age 65 or over. Also, Medicare is a primary payer for Covered Persons under age 65, who are covered by Medicare because of disability (other than end stage renal disease), when (1) the Employer employs fewer than 100 employees and the Covered Person or their spouse or parent has group health plan coverage due to current employment, or (2) the Covered Person or their spouse or parent has coverage not due to current employment, regardless of the number of employees of the Employer.

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

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

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

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

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

As required by the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), if your eligibility for group coverage under the Plan ends because of one of the qualifying events shown below, you may be eligible to continue group coverage as shown below.

A. CONTINUATION OF GROUP COVERAGE

1. Qualifying Events. Coverage under the Plan may be continued by a covered employee, covered dependent spouse and other covered dependents, enrolled at the time coverage would otherwise end, or a child born to or placed for adoption with the covered employee during the period of continuation coverage, as a result of one of the following qualifying events:

   a. Termination of employment (except for gross misconduct) of the covered employee, or reduction in hours resulting in a loss of group coverage.
   b. Death of the covered employee.
   c. Divorce or legal separation of the covered employee.
   d. Loss of eligibility as a covered dependent child.
   e. Initial enrollment of the covered employee for Medicare.
   f. For a retired covered employee, spouse and other dependents, the bankruptcy filing by a former Employer, under Title XI, United States Code, on or after July 1, 1986.

2. Duration of Continuation Coverage. The maximum period coverage can be continued depends on the qualifying event. Continuation coverage may be terminated earlier as shown below. The maximum period of continuation coverage starts on the day of the qualifying event.

   a. Maximum period
      (1) Termination and reduced hours. The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the Employer’s bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months.
      (2) Disabled covered employee, covered dependent spouse or covered dependent child. If the covered employee, covered dependent spouse or other covered dependent is disabled under Title II or XVI of the Social Security Act, at the time of the termination of employment, or reduced hours of the covered employee, or within the first 60 days of continuation of coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the Plan Sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months.
      (3) Bankruptcy. In the case of bankruptcy of a retired covered employee's former Employer, the maximum period of continuation coverage is until the death of the retired covered employee. In the case of the surviving spouse or dependent children of the retired covered employee, the maximum period of continuation coverage is 36 months after the death of the retired covered employee.
      (4) Divorce or legal separation. The maximum period of coverage for a former spouse or dependents who lose coverage due to divorce or legal separation is 36 months.
      (5) Death of covered employee. The maximum period of coverage for a covered dependent surviving spouse and covered dependents who lose coverage due to the death of the covered employee is 36 months.
      (6) Other qualifying events. The maximum period of continuation coverage for all other qualifying events is 36 months.
b. **Earlier Termination**

Coverage terminates before the end of the maximum period if any of the following occurs.

1. **End of the Plan.** The Plan under which this coverage is offered to covered employees is terminated.
2. **Failure to pay premium.** The person receiving continuation coverage does not make the monthly payment within 30 days of the due date.
3. **Other group health coverage.** The person receiving continuation coverage becomes covered under any other group health type coverage, not containing an exclusion or limitation for any pre-existing condition of the person. If the other group health coverage contains a pre-existing condition limitation, continuation coverage is extended until the pre-existing limitation is satisfied or coverage is otherwise terminated. A person will not be subject to earlier termination of continuation coverage on account of coverage under another group plan that existed prior to that person’s first day of continuation coverage.
4. **Termination of extended coverage for disability.** In case a person receives extended (29-month) continuation coverage due to disability at the time of termination or reduced hours, the extended coverage terminates at the beginning of the month 30 days after a final determination that the person is no longer disabled.
5. **Termination provisions of this Summary Plan Description.** The person’s coverage is subject to termination under section [I.] of this Summary Plan Description.
6. **Enrollment under Medicare.** The person receiving continuation coverage becomes entitled to and covered under Medicare Part A or B coverage. A person will not be subject to earlier termination of continuation coverage on account of coverage under Medicare that existed prior to that person’s first day of continuation coverage.

3. **Election of Continuation Coverage**

a. You have 60 days to elect continuation of group coverage. The 60-day period begins on the date your group coverage would otherwise terminate due to a qualifying event or the date on which written notice of your right of continued group coverage is mailed, whichever is later.

b. If you wish to continue group coverage as shown above, you must apply in writing to your Employer (not the Plan Manager). You must also pay your first monthly payment within 45 days of the date you elected to continue group coverage. Thereafter, your monthly payments are due and payable at the beginning of each month for which coverage is to be continued.

c. You or your covered dependents must notify the Plan Sponsor within 60 days, when divorce, legal separation, a change in status resulting in a loss of eligibility as a dependent would end coverage or a second qualifying event occurs. The 60 day period begins on the date of the divorce, legal separation, change in dependent status or second qualifying event.

4. **Procedures for Providing Notices Required Under This Continuation of Group Coverage Section**

a. You must comply with the time limits for providing notices required in paragraph 3 (c) above.

b. Your notice must be in writing and contain at least the following information:

   1. the names of the covered employee and covered dependents;
   2. the qualifying event or disability; and
   3. the date on which the qualifying event (if any) occurred.
c. Your notice must be sent to:

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

The Plan will comply with applicable federal law for a covered employee that is called to active military duty in the uniformed services.

B. REPLACEMENT OF COVERAGE AND CONFINED COVERED PERSONS

When the Plan Sponsor replaces the Plan with that of another medical plan offering similar benefits, coverage will be extended for a Covered Person who is confined in an institution or institutions for medical care or treatment that would otherwise be covered under the Plan. Coverage will be extended only for services related to the condition for which the confinement is required. Coverage for these services will end on the earlier of the date of discharge or the date benefits provided under the Plan are exhausted.

VIII. CLAIMS PROCEDURES

A. PROCEDURES FOR REIMBURSEMENT OF NETWORK SERVICES

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

B. PROCEDURES FOR REIMBURSEMENT OF SERVICES

1. Claim Forms. If claim forms are needed, please contact the Plan Manager at (952)883-7500 or 1-866-270-5434. For hearing-impaired individuals, call (952) 883-5127 or toll-free at 1-888-850-4762. You must submit claims to the Plan Manager for out-of-network services on the claim form provided. Claim forms must include written proof which documents the date and type of service, provider name and charges, for which a claim is made.

2. Proof of Loss. Claims for services must be submitted to the Plan Manager at the address shown below. You must submit an itemized bill, which documents the date and type of service, provider name and charges, for the services incurred. Claims for services must be submitted within 90 days after the date services were first received for the injury or illness upon which the claim is based. Failure to file a claim within this period of time shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within that time. However, such claim must be filed as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than 15 months from the date services were first received for the injury or illness upon which the claim is based. If the Plan is discontinued or if HPAI ceases to act as the Plan Manager, the deadline for claim submission is 180 days. The Plan Manager may request that additional information be submitted, as needed, to make a claim determination.

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

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

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

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

C. **TIME OF NOTIFICATION TO CLAIMANT OF CLAIMS**

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

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

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

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

2. **Post-Service Claims.**

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

You will receive written notification of any initial adverse claim determination as provided by applicable law.
D. CLAIM DENIALS AND CLAIM APPEALS PROCESS FOR PRE-SERVICE CLAIMS

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

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

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

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

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

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

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

   The time periods may be extended if you agree.

   All notifications described above will comply with applicable law.

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

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

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

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

   The time periods may be extended if you agree.

   All notifications described above will comply with applicable law.
E. CLAIM DENIALS AND CLAIM APPEALS PROCESS FOR POST-SERVICE CLAIMS (all claims except requests from CareCheck® for pre-certification)

If your post-service claim for benefits under the Plan is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the named fiduciary of your Plan or its delegate. You must exhaust both levels of appeal prior to bringing a civil action. The steps in this appeal process are outlined below.

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

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

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

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

   The time period may be extended if you agree.

   All notifications described above will comply with applicable law.

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

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

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

   The time periods may be extended if you agree.

   All notifications described above will comply with applicable law.